



BMA

Resident doctors' handbook

A guide to the main contractual issues
that face resident doctors today

June 2015



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Introduction



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Introduction

The Resident doctors' handbook 2015

This handbook is your guide to the main contractual issues that may arise in resident hospital doctors' employment and on which you may need to seek advice. The guidance in this handbook covers the UK position and where there are different arrangements in any of the four nations, these have been highlighted.

The handbook has been produced to provide information to help resident doctors understand their terms and conditions of service and matters arising in the course of their employment. Every effort was made to check accuracy at the time of printing but there may have been later changes. Members should also check the BMA website for updates since the time of publication.

BMA members may seek advice, from our team of advisers, on specific problems relating to the terms of their employment by visiting bma.org.uk/contactus

The Association is happy to receive any comments on the handbook, or any suggestions on how to improve the services provided for resident doctor members. Comments should be sent to the resident doctors committee at info.RDC@bma.org.uk

June 2015

Training
appointments
and educational
approval

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Training appointments and educational approval

Summary

This chapter covers the key approvals required before a post can be recognised for training.

It explains which organisations hold responsibility for approving training programmes and posts, as well as the types of posts that may not count towards a CCT.

All training posts must have educational and dean's approval and this should be clearly stated in advertisements. Resident doctors should be aware that non-approved or non-standard posts will not count towards a CCT (certificate of completion of training). Resident doctors who have any concerns about a post should always seek advice from their postgraduate dean. All specialty training and fixed-term training appointments must adhere to national person specifications, which are available on the Health Education England website (<http://specialtytraining.hee.nhs.uk/>) and the Scottish Medical Training Website (www.scotmt.scot.nhs.uk).

NHS training posts must be of an acceptable standard and accord with NHS workforce agreements. The following key features must apply to all training posts:

- a post or programme must have educational approval and approval by the postgraduate dean or it cannot be designated a training post or programme
- a post not in a recognised NHS training grade (eg ST level Trust post/clinical fellow) cannot be regarded as a recognised training placement or programme. Experience in such non-training posts cannot be assumed to count towards the completion of specialty or general practice training
- placements or programmes in NHS training grades for doctors and dentists can only be advertised if they have the valid educational and dean's approval.
- all recruitment procedures should comply with equality and diversity policies.

Employers must seek permission from the postgraduate dean whenever it is proposed to advertise a training placement or programme. Before the advertisement can appear, the postgraduate dean must confirm that:

- there is valid educational approval
- there is current postgraduate dean's approval

The following two elements must be met for a post to obtain the postgraduate dean's approval:

- posts must meet agreed standards on training, supervision, contractual terms, compliance with the New Deal, accommodation and catering and local human resources strategy
- where there is a national or specialty-specific target for the number of doctors or dentists to be trained, the dean's approval must not be granted to placements that may cause these targets to be breached.

GMC (General Medical Council) approval of experience

If a doctor has been in an educationally approved post in the UK (eg SHO, LAT or FTSTA¹) they can enter specialty training at an appropriate point above ST1 and proceed to a CCT (certificate of completion of training). The national person specifications outline the experience requirements for each level. If their posts have offered experience but have not been educationally approved, they can still enter beyond ST1, but will need to join the Specialist Register by the Article 14 (CESR (Certificate of Eligibility for Specialist Registration)) route.

Prospective approval of posts

The GMC does not retrospectively approve non-training posts for doctors hoping to gain a CCT. As stated above, posts that have offered experience but have not been educationally approved can be used to further training, but will require the doctor to join the Specialist Register by the Article 14 (CESR) route. However, doctors may gain prospective approval of research or overseas posts, which will then count towards a CCT. This approval must be agreed by the GMC and the dean in advance. See www.gmc-uk.org/education/seeking_approval.asp

For further information on OOP (Out of Programme Experience) see chapter 22. Educational and training approval from the GMC is also needed for those placements not funded by the postgraduate dean but by other bodies, eg universities, charitable institutions, or research bodies, non-NHS providers etc.

1 Please note – at the time of printing, in England, LATs or FTSTAs are in the process of being phased out.

Honorary appointments

An honorary appointment gives a doctor formal status at an employer. It does not provide a salary or require formal work but can open opportunities to undertake paid work and access appropriate expenses. Employers offering honorary NHS appointments to doctors wishing to gain experience in order to pursue clinical specialist training must obtain the dean's approval before the placement is advertised or the appointment confirmed.

LASs (Locum Appointments for Service)

Locum doctors and dentists should not be appointed to training grades where there is no substantive placement to be covered. Locum appointments (apart from Locum Appointments for Training – LATs²) will not normally be recognised for training purposes. Applicants should be told before appointment that, although the substantive placement may attract the relevant approvals, a locum appointment should not be assumed to count towards a CCT. Advice about prospective approval of training for locum hospital placements should be sought from the GMC and the postgraduate dean.

Non-standard grades

Employers have been told by the BMA that non-standard titles can also be misleading and that they should not use them. The following substantive standard training grade titles are listed in the Terms and Conditions of Service for resident doctors and are open for appointment: StR (specialty registrar), StR(FT) (specialty registrar (fixed term)) or FTSTA (fixed term specialty training appointment), StR(CT) (specialty registrar (core training)), F1 (foundation doctor 1), F2 (foundation doctor 2).

If you are applying for a non-standard grade it is important that you read the terms of the recruitment advertisement carefully and check whether the post you are considering applying for has educational approval.

2 Please note – at the time of printing, in England, LATs are in the process of being phased out.

Responsibility for educational approval

F1 grade

The learning objectives for this year are set by the GMC. In order to attain full registration with the GMC, doctors must achieve specific competences by the end of this year. The postgraduate dean normally undertakes responsibility for approving trainees' competences.

F2 grade, specialty training grades and fixed term specialty training appointments

The GMC is required to recognise and approve placements and programmes for the foundation programme and for all specialty training leading to the award of a CCT. The GMC will take advice from the relevant medical royal college or faculty, which approves placements on its behalf. However, not all placements/programmes confirmed by the dean as having educational and postgraduate dean's approval automatically lead to the award of a CCT, eg Locum Appointments for Training and StR(CT). For detailed information on specialty training please read *A guide to postgraduate training in the UK* also known as the *Gold Guide* – this is available for all years at <http://specialtytraining.hee.nhs.uk/the-gold-guide/>

SpR grade

Even though this grade is closed to new entrants, many trainees continue on SpR contracts. These are educationally approved in the same way as the specialty training grades. For detailed information on SpR training please read *A guide to specialist registrar training; NHS Executive 1998*, also known as the *Orange Guide* – http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4006614

Further information

- *A guide to specialist registrar training; NHS Executive 1998*, known as the *Orange Guide*
 - http://webarchive.nationalarchives.gov.uk/+/.www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4006614
 - *A guide to postgraduate training in the UK*, also known as the *Gold Guide* <http://specialtytraining.hee.nhs.uk/the-gold-guide/>
 - *Rough guide to the foundation programme*
 - www.foundationprogramme.nhs.uk/pages/home/keydocs
 - *Foundation programme reference guide*
 - www.foundationprogramme.nhs.uk/pages/home/keydocs
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Learning and development

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Learning and development

Summary

This chapter provides information on learning and development support, tips on choosing a specialty and career progression.

Making a choice of which career path to pursue requires considerable thought. Personal choice needs to be aligned with aptitude, strengths and interests, as well as the extent of competition for, and the availability of, opportunities.

The BMA is committed to supporting doctors throughout their careers and provides a wide range of specialist non-clinical learning and development services. We recognise the importance of continued non-clinical training in helping doctors to advance their careers and to help with demonstrating further valuable learning for appraisal and revalidation.

As a BMA member, your access to these services currently range from free medical careers information and online guidance available 24/7, through to discounted career development workshops, webinars and one-to-one careers coaching. This includes in person and online training, medical careers information, top tips and guides on how to choose a specialty, training recruitment processes and timelines, job vacancies and links to other careers sites.

Our team of qualified trainers and medical careers consultants deliver open workshops and group training at medical workplaces around the UK. We also deliver live webinars and online videos on a variety of professional development topics.

Open career development workshops

These interactive workshops focus on issues specific to you as a resident doctor and are designed to give you the support and guidance you need to develop your true career potential. Topics include:

- interview skills and CV review
- presenting skills for clinicians
- negotiating and influencing
- time management
- management essentials and many more.

Workshops are delivered by highly-qualified medical careers advisers and provide you with the extra skills you need to prepare you for a successful career in medicine. Visit the BMA website to view information about each programme.

Career development webinars

We deliver a suite of webinars that provide real-time teaching delivered live to your computer from a careers expert on topics which are aligned to your training, such as:

- Assertiveness in the workplace
- Making the most of your appraisal
- Options for taking a year out
- Networking for professional development
- Preparing for your specialty application.

We recognise that while in person teaching is ideal, not always do work and other commitments allow for this. Webinars provide a flexible learning approach to careers development, no matter where you are or when you decide to watch.

Free Sci59 online psychometric test

The BMA works with CenMEDIC to provide members with free access to the Sci59 online psychometric test which is designed to provide a list of medical career choices that are impartial and based only on your personal characteristics. The output of Sci59 provides a rational view of the specialties that match your needs.

The questionnaire takes around 25 minutes to complete and feedback is almost instantaneous. Remember, the result acts as a guide for your consideration – it is not a replacement of formal career guidance.

To access the site or for further information please visit bma.org.uk/psychometric

One-to-one careers coaching

Individual career advice is available through a confidential one-to-one coaching service. Designed to meet your specific needs and provide practical solutions to complex career issues and challenges, impartial, independent advisers will provide expert, in-depth analysis at significantly discounted rates to BMA members. For further information please visit bma.org.uk/careercoaching

e-learning module resources for resident doctors

The e-learning modules from BMA Careers offer insightful, practical guidance that puts you in control of your career. Unlike some other career resources, these e-learning modules see things from your perspective. Modules in the series include:

- Maximising your portfolio
- Time Management for foundation doctors
- Effective handover for foundation doctors
- Building professional relationships
- Getting and giving useful feedback
- How to be successful with your application for specialty training
- How to take a career break and have a successful return to work.

Access these exclusive and valuable modules at:

learning.bmj.com/BMA

More career progression benefits from the BMA in partnership with the BMJ

BMA members are entitled to a wide range of benefits from the BMJ. Make sure you support your continued non-clinical learning and career progression needs with:

- free access to BMJ Learning an extensive range of CPD and postgraduate training modules
- discounted BMJ Masterclasses specialist one-day courses to keep you up to date with the latest evidence, new guidelines and best practice
- BMJ Portfolio to evidence your CPD
- discount on BMJ Quality an online platform that will guide you step by step through your quality improvement project
- free access to BMJ Careers, the UK's leading resource of medical jobs
- free weekly print editions of The BMJ
- free online access at thebmj.com, and
- discounted subscriptions to Journals from BMJ (Excluding: BMJ Case Reports, Drug and Therapeutics Bulletin, Veterinary Record and In Practice).

Recruitment to
specialty training
– advice for
applicants

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Recruitment to specialty training – advice for applicants

Summary

Applications for specialty training are made to lead deaneries, LETBs or Royal Colleges.

The specialty training website gives detail on person specifications and application processes.

All applications to specialty training programmes are managed through the online application portal 'Oriel': www.oriel.nhs.uk

Recruitment is either organised locally by the deanery for a specific region (for Scotland it is coordinated by NHS Education for Scotland and as of 2014 Scotland is a single deanery) or for some specialties recruitment is coordinated on a UK-wide basis and led by a specific deanery or royal college.

You should first check the relevant Royal College, LETB or deanery website for information about training programmes and application processes. You should also ensure that you meet the criteria listed in the person specification for the training programme to which you will be applying.

You can apply to training programmes during the vacancy window by searching for vacancies on the relevant college, LETB or deanery website, NHS jobs online or on the Oriel website. You will be shortlisted for interview against the criteria listed in the person specification.

HEE (Health Education England) has produced guidance for applicants that includes dates of vacancy windows and its website also links to specific programme descriptors and competition ratios for each specialty.

Applications to the Foundation Programme are managed by the UK Foundation Programme Office using the FPAS system.

If you are in doubt, please check the oriel website or the specialty training website (<http://specialtytraining.hee.nhs.uk/>) for up to date information on applying to specialty training programmes.

Further information

- Frequently asked questions on the BMA website bma.org.uk/developing-your-career/specialty-training/applying-for-a-specialty-training-post
 - Oriel www.oriel.nhs.uk
 - HEE specialty training www.specialtytraining.hee.nhs.uk
 - Specialty training in Wales www.walesdeanery.org
 - Specialty training in Northern Ireland www.nimdtg.gov.uk
 - Specialty training in Scotland www.scotmt.scot.nhs.uk
 - NHS Jobs www.jobs.nhs.uk
 - UKFPO for Foundation Training www.foundationprogramme.nhs.uk/pages/home
-

Recruitment to general practice

The National Recruitment Office coordinates the recruitment to general practice for England, Northern Ireland, Scotland and Wales. More information is available on the National Recruitment Office website at www.gprecruitment.org.uk/

Code of Practice: Provision of information for postgraduate medical training

The Code of Practice has been adopted across the UK. The Code lays out the agreed set of information that recruiting organisations and employers should provide to doctors in training at each stage of the recruitment process, including the first post and subsequent rotations. Under the Code, employers should share the following information at least eight, and preferably 12 weeks in advance:

- Contact details
- Location of work
- Hours and out-of-hours rota
- Basic pay and any supplementary pay
- Pension arrangements
- Leave rules and entitlement

Some resident doctors are still not receiving sufficient notice and in these cases you should first contact your prospective employer or recruiting organisation to address the problem. If this does not resolve the issue then contact the BMA.

More information about the Code is available on the BMA website:
bma.org.uk/practical-support-at-work/contracts/juniors-contracts/accepting-jobs/code-of-practice

Links to the Code of practice can be found here:

- England and Wales: bma.org.uk/practical-support-at-work/contracts/juniors-contracts/accepting-jobs/code-of-practice
- Scotland: www.sehd.scot.nhs.uk/mels/CEL2014_10.pdf
- Northern Ireland: www.dhsspsni.gov.uk/hrd_-_2013_code_of_practice_-_provision_of_information_for_postgraduate_medical_training.pdf

Recruitment to an Academic Clinical Fellowship/ Clinical Lectureships

For more information please visit the relevant page for your region:

Academic Clinical Fellowship/Clinical Lectureships

England and Wales

National Institute for Health Research website:
www.nihr.ac.uk/Pages/default.aspx

Northern Ireland

Training programme from Queen's University, Belfast:
www.qub.ac.uk/schools/mdbs/pgd/CAT/

Scotland

NES (NHS Education for Scotland) website:
www.nes.scot.nhs.uk/

Wales

Foundation Academic Programme information can be accessed via the Wales deanery website at:
www.walesdeanery.org/index.php/en/foundation-training-key-documents/1154-academic-foundation-programmes-afps.html

An overview of the academic training programmes across the UK is available on the BMA website [bma.org.uk/developing-your-career/specialty-training/academic-training](https://www.bma.org.uk/developing-your-career/specialty-training/academic-training)

Top tips on applying for a specialty training post

- Read the programme descriptors carefully.
 - Read the person specifications to ensure your skill set matches with the role you are applying for.
 - Check you know which level you should apply for.
 - Check the competition ratios for each specialty.
 - Check you can back up your experience with sufficient evidence.
 - Find out if your specialty is recruiting through either:
 - locally led by your deanery/NHS Education for Scotland
 - coordinated on a UK-wide basis led by a deanery or royal college.
 - Check the application deadlines (late applications will not be accepted under any circumstances).
 - Find out if you have to submit an application online and how long this will take you.
 - Start planning your applications early and download the application form and ensure you have all the information you need.
 - Read the Specialty Recruitment Applicant Handbook on the specialty training website (www.specialtytraining.hee.nhs.uk) for help and advice on how to best present your skill set and experience in your application. For other nations, please check the relevant websites for further information.
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‘Most resident doctors have little knowledge of their rights or the law and even if they do, they don’t want to cause a fuss. But having a contract is absolutely vital to ensure you are protected.’

Specialty registrar, London

Simply view our guidance to check if your contract conforms to the agreed national model before you sign.

We can help you be as prepared as you possibly can at this vital stage in your career.

Visit bma.org.uk/yourcontract

Contracts of employment

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Contracts of employment

Summary

This chapter covers model contracts of employment, individual contracts of employment, job descriptions and notice periods.

It explains the different types of employer and provides some information on the circumstances where local variations can be made to national terms and conditions of service. It also includes a brief summary of the F1 shadowing period.

- Each time you rotate to a new employer you should receive a contract. The only exception to this is if you are employed by a lead employer organisation, which holds all the contracts. If you have a lead employer this normally means you will have just one employer while rotating within that deanery/LETB area.
- Within two months of starting with a new employer you should receive a written statement of particulars of employment. This will normally be a contract of employment and a job description. Further information is available in the Code of practice: Provision of Information for Postgraduate Training bma.org.uk/practical-support-at-work/contracts/juniors-contracts/accepting-jobs/code-of-practice
- If you haven't received this contractual information contact our team of advisers by visiting bma.org.uk/contactus
- Once you have received your contractual information view our guidance, <https://www.bma.org.uk/pay-and-contracts/contracts/your-contract-of-employment/your-contract-of-employment>, to ensure it complies with the national model where appropriate.

Model contracts of employment

One model contract is designed to be applicable to all resident doctors in the training grades. This is reproduced at Appendix I of this handbook. For the Scotland model contract, see Circular PCS(DD)2007/7. Doctors who carry out academic work should also refer to the medical academics section, chapter 23, for information on medical academic employment contracts. The model contract covers the specific terms of each employment contract and is subject to the TCS (Terms and Conditions of Service of Hospital Medical and Dental Staff) and the GWC (General Whitley Council) conditions of service.

Individual contracts of employment

A contract of employment is an important legal document. The model contract has been agreed at a national level between the UK RDC (resident doctors committee), NHS Employers in England and the health departments in the devolved administrations. Once signed, the contents are binding and it may be impossible to make changes. Contracts should follow the national models

but some employers include clauses that differ from those national agreements. These should be no less favourable than the model contract. If you are concerned that your contract falls below the minimum terms and conditions set out in the model, contact the BMA for advice.

Honorary contracts

An honorary contract is distinct from a substantive contract of employment. It gives a doctor formal status with an employer and can open opportunities to undertake paid work and access appropriate expenses, but does not provide a salary or regular employment. An honorary contract with an NHS employer might be held by a doctor who works primarily in an academic institution but remains clinically active. An honorary contract with an academic employer might be held by a doctor who works primarily within the NHS but who also undertakes academic research. This chapter discusses substantive contracts.

The RDC urges that resident doctors who are BMA members, use the BMA guide to check that the employment contract offered is in accordance with the nationally agreed model. If a contract does not conform to the national model, residents should give written notice to their employer that they do not accept a non-standard contract and they should not sign it without first seeking advice.

You can go to our website for more information: bma.org.uk/pay-and-contracts/contracts/your-contract-of-employment/your-contract-of-employment. Or contact our advisers by visiting bma.org.uk/contactus

Further information

- BMA website: bma.org.uk/practical-support-at-work/contracts/juniors-contracts
 - Model contract: www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/junior-doctors-dentists-gp-registrars/other-contractual-documents
 - Scotland model contract PCS(DD)2007/7 (Scot) Annex C [www.sehd.scot.nhs.uk/pcs/PCS2007\(DD\)07.pdf](https://www.sehd.scot.nhs.uk/pcs/PCS2007(DD)07.pdf)
 - Northern Ireland model contract www.dhsspsni.gov.uk/hss__tc8__3-2007__revised__-introduction_of_the_specialty_registrar_grade_including_fixed_term_specialty_training_appointments.pdf Annex C
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Job descriptions

A job description should accompany the contract and forms part of the contractual relationship between the resident doctor and the employer. Ideally, the doctor should be given a copy of the job description on application for the post. The job description should provide an accurate picture of the post and define the hours (including details of the rota) and duties of the job. The RDC recommends that the rota, in particular, is provided by the employer a minimum of six weeks before the doctor is due to begin a placement.

The position set out in the Code of Practice for Scotland is that this should normally be provided no later than four weeks in advance. In Northern Ireland, this information has to be provided with a minimum of six weeks notice.

Alterations to the job description should be by mutual agreement. Contact our team of advisers by visiting bma.org.uk/contactus, if in any doubt.

The Code of Practice has been adopted across the UK. These contain differences of detail:

England and Wales: bma.org.uk/practical-support-at-work/contracts/juniors-contracts/accepting-jobs/code-of-practice

Scotland: www.sehd.scot.nhs.uk/mels/CEL2014_10.pdf

Northern Ireland: www.dhsspsni.gov.uk/hrd_-_2013_code_of_practice_-_provision_of_information_for_postgraduate_medical_training.pdf

Notice periods

The following minimum periods of notice should apply, (section 195 and 196 in the Terms and Conditions of Service) unless there is an agreement between both parties that a different period should apply:

F1	2 weeks
F2	1 month
Specialty registrar (fixed term)	1 month
Specialty registrar (core training)	1 month
Specialty registrar/specialist registrar	3 months

Additionally, Section 86 of the Employment Rights Act 1996 (Employment Rights (NI) Order 1996 in Northern Ireland) provides entitlement to minimum periods of notice, dependent upon an employee's length of continuous employment. For hospital medical and dental staff these are as follows:

Period of continuous employment	Notice entitlement
1 month or more, but less than 2 years	Not less than 1 week
2 years or more, but less than 12 years for each year of continuous employment	Not less than 1 week
12 years or more	Not less than 12 weeks

Employment documentation

It is worth remembering to obtain the relevant documentation when starting work with a new employer. A staff transfer form, a P45, a GMC annual registration certificate, a recent payslip and proof of hepatitis B status would all, if readily available, facilitate your early days in a new job.

Employers should accept an original recent payslip as provisional confirmation of a doctor's salary increment and incremental date and should pay the doctor accordingly, pending receipt of the NHS transfer form, which will give final confirmation. Having a recent payslip will ensure that you are not placed on the lowest increment of a grade pending confirmation.

A checklist is available on the BMA website covering all of the above, which serves as a useful reminder when rotating. A model letter of acceptance is included in the model contracts, referenced at the start of this chapter.

Further information

- BMA advice [bma.org.uk/practical-support-at-work/contracts/juniors-contracts](https://www.bma.org.uk/practical-support-at-work/contracts/juniors-contracts)
 - Terms and conditions of service, paras 195-98
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Resident doctors' employers

Resident doctors' contracts are made with and held by individual NHS employers, such as Trusts or Health Boards. This means that employers are distinct from the organisations ultimately responsible for resident doctors' educational provision. Chapter 2 discusses how these bodies exercise their duties to ensure the educational value of training posts.

Foundation programme employers

The RDC recommends that doctors in the foundation programme are employed by one employer acting as a 'host employer' during the two-year programme. (In Scotland 'host employer' arrangements are not in place and trainees are issued with employment contracts covering the length of their individual placements.) The host employer would usually be the employer where a trainee is based for the majority of their programme. The host employer would then second the foundation trainee to any other employers that form part of the programme. Even where this arrangement does not exist, foundation trainees will need to be seconded from their last employer to a GP practice when undertaking a GP placement.

Lead employers

It is open to employers to join together to agree an arrangement whereby one employer administers contracts on behalf of a group of employers. In such cases the 'lead' employer may hold all contracts and second resident doctors from that employer to others. Such arrangements should assist in better planning and organisation of training rotations, and the RDC strongly approves of them. Members offered contracts in which they will be seconded from one employer to another should view our guidance [bma.org.uk/pay-and-contracts/contracts/your-contract-of-employment/your-contract-of-employment](https://www.bma.org.uk/pay-and-contracts/contracts/your-contract-of-employment/your-contract-of-employment) before signing the contract

Variations to national agreements on contracts and terms of service

Although employers are required to employ resident doctors on national Terms and Conditions of Service, they have some flexibility to introduce variations to the national model contracts for specialist and specialty registrars. However, this flexibility should be only at the margins of terms and conditions of service, and usually involve additions or modifications to enhance rather than reduce existing rights. It is intended that residents should hold a uniform contract throughout a rotational training programme, with only the employer's identity changing as they move between posts in the rotation.

Any local variations to national agreements on contracts and terms of service must meet the following important conditions:

- they have been negotiated with local resident doctors' representatives, and through the LNC (Local Negotiating Committee);* and
- the postgraduate dean is satisfied that they will not adversely affect quality of training; and
- they are agreed by all the employers in the rotational training programme.

* For more information on LNCs, including how you can become involved, see the BMA website bma.org.uk/lnc

It is essential that resident doctors' representatives are involved at all stages in any negotiations aimed at seeking variations to national agreements and that the above safeguards are met. Generally, discussions will be held at deanery level and proposals will need to be endorsed by each employer and its LNC. It is therefore crucial that the LNC has a resident doctor representative who is able to attend meetings.

Regional RDCs may have appointed negotiators who take the lead in any discussions at deanery or lead employer level. Resident doctors should seek advice from their local representative or LNC chair if they are aware that changes are being considered without any resident doctor input. They can also contact our advisers by visiting bma.org.uk/contactus

In Scotland, health boards must employ resident doctors on national pay and conditions and can only introduce any flexibility if they apply for and receive a variation order from the Scottish Government Health and Social Care Directorate.

Vacant posts

The terms of any job description can be reviewed in light of the level of service required where posts fall vacant. Proper consultation must, however, take place and the employer is required to consult those most closely involved with the posts, including the consultants and other resident doctors on the shift/rota and, so far as possible, the previous incumbent. Any changes can only be made as a result of these consultations, but the new incumbent may seek an immediate review if the revised allocation of duties is unrealistic. You can seek advice from our team of advisers by visiting bma.org.uk/contactus

Training agreements

In addition to the employment contract, resident doctors should also have an individual training agreement agreed between the postgraduate dean, the employer, and the trainee to ensure that each party knows how the training and service components of the post will fit together. In practice there is rarely a formal and individual training agreement, however you may find in certain posts you are asked to sign an educational agreement as part of your curricular portfolio.

F1 shadowing

Shadowing is an arrangement where a prospective doctor observes an existing F1 (foundation doctor) undertaking the usual activities required of their role before taking over the role themselves. It helps forthcoming F1 doctors become more familiar with working practices and hospital systems, gain confidence and professional skills and helps to improve patient care. It can also provide an opportunity to develop working relationships with the clinical and educational supervisors they may work with in the future.

All new F1s across the UK should receive at least four days paid shadowing at the basic F1 salary rate (£26,614 annually) pro rata to the hours undertaken. The BMA believes that this should be calculated on the basis that the hours undertaken in a four day shadowing period (32 hours) are four fifths of the full hours (40 hours) for which an F1 doctor is paid in a week. If your new employer says they will not be paying you for shadowing, or if it is not calculated at this rate, please contact the BMA by visiting bma.org.uk/contactus

There are no nationally agreed contractual arrangements in England for F1s undertaking paid shadowing placements. RDC believes that the best approach is for a full employment contract to be used as this allows new F1s to engage fully in clinical activity whilst shadowing.

The new 2016 terms and conditions of service include a clause stating that the terms should not be used for the period of shadowing and that separate arrangements should be made (introduction, paragraph 3). A copy of the 2016 TCS with this clause removed can be used for this purpose for the F1 shadowing period.

Comprehensive information on shadowing is available on the BMA website.

Further information

- BMA information <https://www.bma.org.uk/advice/employment/contracts/juniors-contracts/assistantships-shadowing-and-induction/shadowing>
 - HEE guidance https://www.nwpgmd.nhs.uk/sites/default/files/HEE%20Shadowing%20Guidance%202014_0.pdf
 - NHS Employers advice: <http://www.nhsemployers.org/your-workforce/recruit/national-medical-recruitment/foundation-programme/foundation-programme-shadowing-payment-arrangements-2015>
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Salaries

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Salaries

Summary

This chapter provides information on salaries for resident doctors including information on: salary scales, the importance of checking payslips, starting salaries, incremental dates, counting of previous service and additional payments such as London weighting and private fees.

Resident doctors are paid on national pay scales which are set each year. The DDRB (Doctors and Dentists Review Body) receives evidence from the BMA, the UK Health Departments and NHS Employers. The DDRB then reports to the Secretary of State for Health and to the equivalent for Scotland, Wales and Northern Ireland with their recommendations on how to set the pay scales for the year. The report is later made public, with each government making the final decision on whether to implement it in each of the four nations. Any change is usually effective from 1 April each year.

If an announcement is made after the 1 April then any increase will be backdated to that date. The DDRB may recommend an increase to the pay scales but it may also recommend that pay should remain the same. Each of the health departments then has the ability to accept the recommendations of the DDRB or, as is sometimes the case, reduce what is recommended due to the availability of funding.

Each grade has its own pay scale. There are currently:

- three points on the foundation doctor 1 scale
- three points on the foundation doctor 2 scale
- 10 points on the SpR (specialist registrar scale)
- 10 points on the StR (specialty registrar scale)
- six points on the specialty registrar (core training) scale; and
- six points on the specialty registrar (fixed-term) scale.

The top three points of the SpR and StR scale are in theory 'discretionary'. In practice the award of the points should be automatic unless, for example, an employer is already taking action in respect of unsatisfactory performance. Please contact our advisers by visiting bma.org.uk/contactus if problems occur in this area.

Further information

- Pay Circulars for England: www.nhsemployers.org/your-workforce/pay-and-reward/pay/pay-and-conditions-circulars/medical-and-dental-pay-and-conditions-circulars
 - Pay Circulars for Scotland: [www.sehd.scot.nhs.uk/pcs/PCS2014\(DD\)01.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2014(DD)01.pdf) and www.msg.scot.nhs.uk/wp-content/uploads/PCSD20141-Addendum.pdf
 - Pay Circulars for Northern Ireland: TC8 9/2013: www.dhsspsni.gov.uk/hsc__tc8__9_2013_-_pay_and_conditions_of_service_for_hospital__medical_and_dental_staff_-_pay_award_2013.pdf
 - Pay Letters for Wales: www.wales.nhs.uk/nhswalesaboutus/workingforhswales/payconditions/payandconditionsresources
-

Check your payslip

You should always check your payslip when you change post, or change employer, as this is when most errors tend to occur. The key things to look for on your payslip are basic salary, incremental date, superannuation, NI (National Insurance) number and your tax code. Your salary may change for a number of reasons:

- **Pay banding** – Your pay banding remunerates you for additional work you undertake over your basic hours, and for the antisocial nature of your hours. By ensuring you are on the correct point of the pay scale you will also ensure that supplementary payments reflecting your pay banding are correct.
- **Annual increment and your grade on the pay scale** – Sometimes an increase in pay banding supplements could mean that you are not aware of a decrease in your basic salary. A resident doctor's basic salary (excluding pay banding supplement) should increase on promotion to a higher scale.
- **DDR B award** – Each year the DDR B considers evidence from the BMA, the UK Health Departments and the employers, and then issues a report outlining its recommended pay award for the next 12 months. This is in addition to your annual increment. Although the DDR B report is published in the spring it takes time for new pay scales to be issued. Assuming there is a pay award for that year then you normally will not see it in your payslip until May. You will normally receive pay on the new scale one month, followed by arrears of pay for preceding months back to April in

the following month. It cannot be guaranteed that the DDRB will recommend a pay increase every year but on those years that an increase in basic pay is recommended make sure you check your payslip carefully.

- **Other deductions** – The main deductions are income tax and National Insurance contributions, as explained above, as well as student loan and pension contributions. However you may also have other deductions on your payslip – eg for car parking permit, childcare vouchers. These deductions can only be made by your employer with your consent. You should raise any queries regarding these direct with your employer (normally the payroll department).

There is detailed guidance on the BMA website which can help you check your payslip and details how pay changes and what to look out for, particularly when changing post: bma.org.uk/practical-support-at-work/contracts/juniors-contracts

Starting salaries and retention of higher grade salaries

Resident doctors are normally paid at the minimum of the salary scale on appointment to a grade. However, if resident doctors have previous service, employers should appoint them to a salary level beyond the minimum of the scale and sometimes even to the maximum point that previous service allows. They cannot, however, appoint to an incremental point of a grade which is different to the grade being entered unless protected salary arrangements apply.

Further information

- Terms and conditions of service para 121
 - BMA website bma.org.uk/practical-support-at-work/pay-fees-allowances/juniors-payslip-explained
-

Incremental dates

The incremental date will usually be the date of taking up the post in a new grade, although there are some exceptions:

- where previous service is counted, the number of completed months' service will determine the incremental date.

Further information

- Terms and conditions of service paras 122 to 125
-

Counting of previous service

Regular appointments

Where a resident doctor is appointed to a post in a grade having already given regular service in one or more posts in that grade, or in a higher grade, all such service will be counted in full in determining starting salary and incremental credit.

Hospital service in all UK nations, the Isle of Man and the Channel Islands, should be counted as service in the equivalent grade for the purposes of incremental credit and protection of salary.

Locum posts

Where a resident doctor has held a regular appointment in a grade or higher grade, all subsequent locum service in that grade (or higher grade) will count towards incremental credit as though it had been service in a regular post.

All other locum service counts towards incremental credit as though it had been service in a regular post but only at half rate. However, only service of three or more continuous months duration will be considered. Service by agency locums counts in the same way as that by NHS locums. Service in a LAT (Locum Appointment in Training) post counts in full for incremental credit, even if this is the trainee's first appointment in the specialist registrar/StR grade.

Counting of service while on annual leave

Absence on annual leave counts for incremental purposes.

Counting of service while on maternity leave

Absence on maternity leave counts for incremental purposes.

Service outside NHS hospitals

Equivalent service or service in a higher grade outside NHS hospitals including overseas service, other than locum service, may be considered for incremental purposes. Please contact our team of advisers via bma.org.uk/contactus for further information

Practitioners in the training grades who are required as part of their approved training programme to work in non-NHS organisations shall be guaranteed continuity of service for employment purposes.

Further information

– Terms and conditions of service, paras 81(a) and 125

Promotion increase

Where a resident doctor has been paid in their previous regular appointment at a rate of salary higher than or equal to the rate which they would be paid at the bottom of the scale on taking up their new appointment, then the starting salary in the new appointment should be fixed at the point in the scale next above that previous rate, or at the maximum of the scale if the previous rate had been higher.

A resident doctor's basic salary (excluding banding supplement) should not decrease on promotion to a higher grade. The rate of salary paid in previous appointments only includes basic pay for these purposes.

If, prior to taking up a regular appointment as a specialist/specialty registrar, a doctor has undertaken a locum appointment in this grade, the incremental date can be brought forward. If a doctor has not held a regular appointment in the grade before the locum service, completed locum service of at least three months will be counted at half rate. If the locum service followed a regular appointment in the grade, it will be counted in full.

Increments on first appointment to a grade**Specialty registrar**

On first appointment as a specialty registrar, one increment and one only should be given for any more than two years' service spent previously in the F2 and/or SHO grade.

Further information

– Terms and conditions of service, paras 130 and 133

Protection of higher grade salary

Where a practitioner takes an appointment in a lower grade for the purpose of obtaining approved training (which could include training to enable the resident doctor to follow a career in another specialty), the doctor, while in the lower grade, is eligible to receive pay protection provided they have been in the higher grade for 13 months or more. Such a practitioner will receive either their protected salary or the appropriate training grade salary including banding supplement, whichever is more beneficial. Total pay with respect to the protected salary will include payment for additional hours and duties as if those duties had been carried out under the terms of the previous (higher grade) contract.

On re-appointment to the higher grade, the starting salary should be assessed as if the period spent in the approved training grade had been continuous service in the previous higher grade. A resident doctor seeking to retain their higher grade salary should make an application to do so to the new employer prior to taking up the new post.

Resident doctors will need to prove to their new employer that the appointment in the lower grade has been taken in order to further a postgraduate training programme. Therefore, written evidence to this effect should be obtained from the former employer and/or regional postgraduate tutor or dean.

If a resident doctor takes a lower graded post in order to fulfil examination criteria, the employer is under no obligation to grant retention of the higher salary automatically. Such applications should be considered on their individual merits by the employer.

Further information

– Terms and conditions, paras 132 and 135e

Overpayment or underpayment of salary

There may be occasions where salaries have either been over- or underpaid. In cases where overpayment has been established the BMA would expect there to be a negotiated repayment schedule, rather than repayment in a lump sum, to avoid any financial hardship. No monies should be deducted without consent and no interest should be charged on the monies owed. We would however expect that any underpayment be repaid at the earliest opportunity and in full.

In both situations, members are advised to contact our team of advisers via bma.org.uk/contactus

London weighting

Resident doctors should be paid London weighting if their hospital is within a specified area. There are two zones – a London zone and a fringe zone – and different rates apply to each. A reduced rate of London weighting is payable to resident staff who receive their accommodation free of charge or who are paying lodging charges. However, compulsorily resident doctors occupying free single accommodation who also maintain a separate home within reasonable daily travelling distance of the hospital should receive the full rate of London weighting.

Doctors on rotations moving from posts that do not attract London weighting to posts which do, or from posts attracting the fringe London weighting to posts attracting the inner London weighting, in their second or subsequent placement in a rotation, may exercise the option to receive the appropriate London weighting allowance in place of excess travelling expenses.

Medical academic staff

Provided resident doctors have an honorary NHS contract in addition to their university contract, they should be eligible for the above provisions. Those with university contracts only may find their conditions vary according to each university.

Refer to the medical academics section, chapter 23, for more details, or see the BMA's *Medical academic handbook*.

Private fees for resident doctors

Resident hospital doctors can earn fees for their services to private patients in some circumstances. Where resident doctors attend private patients outside their contracted hours they are entitled to receive payment. In carrying out private work, resident doctors' total hours of work should not exceed New Deal limits. If the private work is done in a self-employed capacity then the EWTD limit of 48 hours per week does not apply. However, for resident doctors it is unlikely that this work will be undertaken in a self-employed capacity. If the work is being done as an employee then the EWTD limit of 48 hours applies across all contracts.

If the attendance is arranged privately, the fee is negotiated between doctor and patient, although resident doctors should be aware that medical insurers will usually only pay for consultant services and all such income is taxable.

If the work is required by the employer as part of its general arrangements for the treatment of private patients, payment is the responsibility of the employer under the normal contractual arrangements and no additional fees are payable.

Fee paying work

Resident doctors, like other hospital doctors, may charge a fee for certain types of medical work. The overriding principle for resident doctors is that work relating to 'diagnosis', treatment or prevention of illness' of NHS patients forms part of their ordinary contractual duties. Examinations and reports 'reasonably incidental' to those contractual duties also form part of their NHS obligations and must therefore be provided without charge. Other examinations and reports, which are not 'reasonably incidental' to their NHS duties may be charged for; these are described as 'category 2' or fee paying work.

Examples of category 2 work are listed in the Terms and Conditions of service in paragraphs 36 and 37. Further guidance can be found on the BMA website: [bma.org.uk/practical-support-at-work/pay-fees-allowances/fees/fee-finder/fee-finder-junior-contract/payments-for-category-2-work](https://www.bma.org.uk/practical-support-at-work/pay-fees-allowances/fees/fee-finder/fee-finder-junior-contract/payments-for-category-2-work)

If you have any problems with payments for category 2 work, contact our team of advisers via [bma.org.uk/contactus](https://www.bma.org.uk/contactus)

Important note for Scotland

Please note that as a result of the Certificate of Death (Scotland) Act, from August 2014 there will only be one certificate issued to certify death. As of April 2015, the certifying doctor will not receive any payment for completing this form. Forms B and C will no longer be used and the fee that was attached to these forms is no longer available.

Further information

– Terms and conditions of service, paras 32 to 39

Planning working patterns

7

7

Summary

This chapter describes resident doctors' working arrangements in more detail and explains the circumstances in which one type of working pattern is more appropriate than another.

Planning working patterns

The pattern of work, the length of duty period and the frequency of out-of-hours work undertaken by resident doctors are the key features in deciding whether the working arrangement should be a full shift, a partial shift, a 24-hour partial shift, an on-call rota, or a hybrid of these shift types.

It is important to ensure that the correct working arrangement is adopted for the actual work involved and the amount of rest that can be taken during duty periods.

A properly planned rota that is compliant with both the EWTD and the New Deal will enable a good service to be delivered to patients without jeopardising the standard of training available to resident doctors. Though it may be EWTD-compliant, a full-shift rota with too much 'down-time' for resident doctors will not serve the interests of the employer, the residents or the future NHS as it will not provide adequate training opportunities. Similarly, an under-staffed rota will lead to exhausted resident doctors and may also prevent them from attending training sessions or accessing study leave.

Resident doctors should always be involved when a rota pattern is drawn up, and educational supervisors/postgraduate deans must ensure that any working pattern provides adequate opportunity for accessing training. This is enshrined in the rebanding protocol. It is particularly important to remember that colleagues will be taking annual and study leave throughout the duration of the rota. This must be taken into account particularly if prospective cover applies. For further information see the RDC's guidance on rota design on the BMA website.

Different working patterns

Full shifts

Full shifts for resident doctors are based on those used in other services and industry and other health professions such as nursing. A full-shift rota will divide the total working week into definitive time blocks with doctors rotating around the shift pattern. Shifts are usually of eight to twelve hours' duration, but under the New Deal may be up to fourteen hours (although the EWTD rest requirements mean that unless compensatory rest is given, shift lengths must be

a maximum of 13 hours). This means that there will be two or three shifts to cover 24 hours although there can, of course, be more than one doctor on duty at a time. **The principles for planning full shifts are outlined below.**

How to plan a full- or partial-shift rota

- A workload study should be undertaken; this will also provide useful documentary evidence to justify a change in working practices.
 - Other methods should be used first to reduce hours or intensity.
 - Resident doctors should be involved in designing the rota.
 - Consultants should be involved and their support is crucial.
 - Other affected staff groups should be involved (eg nurses, managers).
 - It is essential to build in teaching sessions and handover time.
 - Any full or partial shift should comply with New Deal/EWTD required rest periods.
 - The planned shift should be piloted and then evaluated; often the final shift has to be redesigned several times.
-

Experience has shown that it is not possible to run successful partial shifts with only four or five doctors on a rota.

It is worth noting that simply changing an on-call rota to a partial shift is unlikely to resolve problems of New Deal or EWTD non-compliance. Partial shifts must be planned properly.

The majority of resident doctors today work full shift patterns. Although they are simplest to plan, they may not be suitable for all departments and services. **A full shift pattern is appropriate for providing medical cover where the work is intensive and potentially continuous throughout the 24-hour period.** In such situations the doctors on duty can be expected to spend virtually all of the duty period, except for natural breaks, working or being immediately available for work. Any working arrangement that does not allow four hours' continuous rest overnight on >75% of occasions is of full-shift intensity. All hours in the shift are counted as actual work for the purposes of banding.

Inappropriate full shifts

Some full-shift working arrangements have too much 'down time' for resident doctors. Historically, this was a result of the SiMAP/Jaeger rulings regarding time spent at the workplace (see chapter 8) and many resident on-call working patterns were replaced by full-shift systems. Such full-shift systems are not always appropriate and may lead to periods of inactive time, especially in the out-of-hours period, which will impact upon an individual's overall training time. If resident doctors do not feel the rota is planned well, or if they feel that they are not able to access adequate training opportunities because service delivery is always prioritised, they should notify their medical staffing department and their educational supervisor, and should get involved with redesigning the rota as necessary. For more information see the RDC's guidance on planning working patterns on the BMA website.

On-call rotas

On-call rotas can be worked from home or from the hospital ('resident on-call'). On-call rotas are a suitable working arrangement where the workload is of such a nature that, when working a standard working week, resident doctors are not required to work for a substantial portion of their out-of-hours duty.

In an on-call rota resident doctors work a normal day, Monday to Friday, and are 'on-call' in rotation for the 24-hour period and for weekends. Duty periods will be more than 24 hours in length.

An arrangement where a resident doctor is on-call for only part of the day, for example until midnight or 9am to 5pm at a weekend, is not an on-call rota. It is a shift system, regardless of work intensity, or the terminology used, which may be historical.

The frequency of on-call depends on the number of resident doctors providing cover and is normally expressed as, eg '1 in 4'.

The New Deal stipulates that resident doctors on on-call rotas should expect to get at least eight hours' rest during a period of 32 hours on duty, principally within the on-call period. Where possible the greater part of this rest period should be continuous. At least one half of the out-of-hours duty period should be taken as rest. For a weekday on-call, for example, this would mean at least eight hours'

rest during a period of 32 hours on duty. There must be a minimum of five hours' continuous rest between 10pm and 8am.

On-call patterns and EWTD

It is important to remember that the EWTD and, more importantly, the SiMAP and Jaeger rulings also impose limits on working hours and requirements for rest breaks (or compensatory rest in lieu of rest breaks). Resident on-call rotas are therefore unlikely to comply with the EWTD because all time spent resident counts towards the average weekly working hours limit of 48 hours. However, non-resident on-call patterns should always be considered in preference to a full-shift system where night work is of low intensity.

Partial shifts

Partial shifts are appropriate where the workload is such that a resident doctor is unable to take eight hours' rest during the on-call period, but the work is not of full-shift intensity. Partial shifts involve a variety of work patterns, particularly for night cover, but there is usually a significant routine workload during the day. Under the New Deal, a duty period should generally not exceed 16 hours, but up to 24 hours is permitted provided rest is adequate and an adequate period of time off is allowed afterwards. However, it is important to remember, in addition, the limits on hours and the requirement to achieve rest (or obtain compensatory rest instead) set out in the EWTD, and the planning of a partial shift therefore must pay close attention to the SiMAP/Jaeger rulings.

The New Deal states that doctors working partial shifts should be able to take, in addition to natural breaks, at least four hours of rest during every duty period of 16 hours. At least one quarter of the out-of-hours period should be taken as rest. For example, a duty period of 5pm to 9am, Monday to Friday should allow four hours' rest.

Partial shifts, when compared with full shifts:

- may be better for training
- need not involve a week of nights
- may allow more weekends off.

On a well-designed six person partial-shift rota, part of two weekends in six would be worked, which would be little different from a 1 in 6 on-call rota with split weekends, but with more time off during the week.

The RDC has produced detailed guidance on working patterns jointly with the Departments of Health and NHS Confederation. There is also RDC guidance on designing rotas and on the relationship between the New Deal and the EWTD (*The final countdown*, April 2008). bma.org.uk/practical-support-at-work/pay-fees-allowances/rebanding/

24-hour partial shifts

Under the New Deal it is possible for two shifts within a partial-shift arrangement to be worked consecutively provided the period of continuous duty does not exceed 24 hours. Such shifts must be scheduled to include any time needed for handovers, ward rounds etc. Doctors should not be on duty for more than four hours following the 16-hour period of out-of-hours duty. For weekday working, this means that the shift must finish by 1pm. The next duty period should not start until at least the beginning of the next normal working day.

As with all working patterns, care must be taken to ensure the requirements of the EWTD are met, and partial shifts must take into account the need for all resident shifts to be 13 hours or less to allow enough rest within 24 hours and to avoid the need for compensatory rest. The planning of a 24-hour partial shift must therefore pay close attention to the SiMAP/Jaeger rulings. The RDC believes that working patterns should be planned so that compensatory rest is not ordinarily required. 24-hour partial shifts with a large residential component are therefore not recommended.

Hybrid working arrangements

A hybrid working arrangement consists of two or more distinct working patterns, for example, an on-call rota in gynaecology and a partial shift in obstetrics. These working patterns are either worked concurrently in the same rota or alternate within a time limit of up to one month. Such an arrangement will be appropriate where residents' duties comprise work of substantially different levels of intensity due to different clinical responsibilities.

A shift/rota with insufficient rest or excessive duty periods is not a hybrid but a shift/rota that breaches the New Deal.

The following criteria must be taken into account when implementing a hybrid working arrangement:

- the particular working patterns that are used in the hybrid arrangement will be defined by the expectation of rest
- New Deal hours' limits will apply to each working arrangement used
- contracted weekly duty periods for hybrid working arrangements should be determined by the point between the New Deal contracted hours' limits of each of the working patterns concerned. The point between the hours limits is calculated using the proportion that each arrangement makes to the hybrid. For example, a hybrid combining 50 per cent full shift and 50 per cent on-call rota will have a contracted duty limit of 64 hours per week (between 56 and 72)
- as with all working patterns natural breaks must still apply. However, if doctors are concerned about their working patterns they should contact our team of advisers via [bma.org.uk/contactus](https://www.bma.org.uk/contactus)

Further information

- TCS paras 19 & 20
 - BMA website, resident doctors guide to rebanding [bma.org.uk/rebanding](https://www.bma.org.uk/rebanding)
 - *Rota design made easy*, RDC (2004) available at [bma.org.uk/rotaguides](https://www.bma.org.uk/rotaguides)
 - *The final countdown*, RDC (2008)
 - HDL(2002)33 Rebanding of doctor in training posts (Scotland)
-

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Hours of work and EWTD





Summary

This chapter explains the contractual and legislative restrictions on the hours that resident doctors can work.

It covers the limits on hours and the requirements for rest laid out in the resident doctors contract (often referred to as the New Deal) and in the European Working Time Directive (EWTD) and explains what to do if posts breach either of the regulations.

Hours of work and EWTD

The EWTD and the New Deal impose different limits on working time and rest requirements for doctors so this section should be read in its entirety to understand the key provisions and how they apply to doctors in training. Information on the EWTD should always be read in conjunction with information on the New Deal.

EWTD

Background and history

The EWTD, which came into force in the UK on 1 October 1998 for consultants and other career grade hospital doctors, originally excluded resident doctors. Agreement was reached in May 2000 between the European Parliament and the Council of Ministers on the arrangements for doctors in training, and a timetable setting out how and when the Directive's provisions would apply to resident doctors was included within the Directive (see below). The Directive has been applicable to residents since August 2004 and has applied in full since August 2009.

The phased implementation of the EWTD

August 2000	Timetable was set to incorporate residents into the directive
August 2004	Interim limit of an average 58-hour maximum working week and EWTD rest requirements
August 2007	Interim limit of an average 56-hour maximum working week
August 2009	Deadline for the average 48-hour maximum working week*

* In 2009 some employers were granted an extension to this deadline and allowed an interim limit of an average 52-hour working week to apply to certain posts until August 2011, or exceptionally until August 2012 at the latest. More information is available later in this chapter.

EWTD provisions

The Directive was designed to protect the health and safety of workers by restricting the number of hours an individual can work and by imposing minimum rest requirements for all workers. It imposes a limit on doctors' working hours of 48 per week on average, calculated over a maximum period of six months. The requirements for taking rest breaks are set out below. However, certain derogations apply to resident doctors (see 'Derogations' overleaf).

EWTD rest requirements

The rest requirements which came into effect in August 2004 are as follows (although derogations apply):

- a minimum of 11 hours' continuous rest in every 24-hour period
- a minimum rest break of 20 continuous minutes after every six hours worked
- a minimum period of 24 hours' continuous rest in each seven-day period (or 48 hours in a 14-day period)
- a minimum of 28 days or 5.6 weeks paid annual leave
- a maximum of eight hours' work in each 24 hours for night workers.*

* A night worker is someone who works at least three hours of their daily working time during night time. Resident doctors are unlikely to be classified as night workers. However, this should not be assumed and where there is any doubt each case should be considered on an individual basis.

Opting out of the hours limit

The EWTD is enshrined in UK legislation and is therefore not optional for employees in the UK. However, an individual resident doctor can voluntarily sign a waiver and 'opt out' of the limit on working hours if they wish. This does not opt them out of the rest requirements. The RDC would urge caution where anyone is considering opting out of the hours limit. As a result of the additional contractual limits on working time (see 'New Deal' section later in this chapter for further information), resident doctors can only opt out to work a maximum of 56 hours in any case.

Employers must not pressurise workers to sign an opt out, and they must continue to keep accurate records of the working hours of all doctors, including those who have opted out. Further guidance for resident doctors on opting out is available on the BMA website.

Derogations

The Directive allows national governments to 'derogate' or deviate from its provisions in certain areas in order to ensure that implementation of the legislation is reasonably achievable by employers. Two key derogations apply to resident doctors.

Compensatory rest

In 1997 the Government and the BMA agreed that strict application of the EWTD rest requirements by hospital doctors could prevent the safe delivery of patient care in the UK. As a result, a derogation was agreed that meant that employers do not have to apply the rest requirements as prescribed. They must instead provide equivalent compensatory rest instead for every occasion that the employee does not achieve the rest. The planning of rotas must therefore take account of the requirement to provide compensatory rest when 11 hours of continuous rest each day, and/or an additional 24 hours of continuous rest per week (or 48 hours per fortnight), are not achieved.

The exact method of implementing compensatory rest is still unclear, but the BMA continues to lobby at EU and UK level for improved guidance in this area. The BMA strives to seek a solution that protects safety at work while protecting opportunities for training. If a resident doctor believes EWTD limits are being breached in their job, they should contact our team of advisers via bma.org.uk/contactus. There is a right to complain to the Health and Safety Executive for all workers, who can issue enforcement notices and may fine and prosecute employers who do not comply.

Interim 52-hour limit

In the months leading up to the August 2009 deadline, it became clear that several employers were not going to be able to comply with the average 48-hour working week for all resident doctors in their employment. The Government decided to enact a provision of the Directive that allowed an interim average 52-hour working week to apply until August 2011, or exceptionally under August 2012, for specific rotas or posts that could not comply. This derogation has now ceased.

Medical academic doctors

Resident academic doctors with a substantive NHS contract should be covered by the working time directive where they undertake academic work on a day release basis. They have the same obligation to provide continuity of care for patients as their resident doctor colleagues.

The BMA believes that all time spent working either in the NHS or at the university (aggregated) should count towards the weekly hours limit and rest requirements. However, members should be aware that universities have been resistant to the local application of the EWTD for academic work.

EWTD definition of working time: the SiMAP and Jaeger European Court of Justice cases

The way in which working time is defined under the Directive has had important implications for resident doctors' working arrangements in the UK. Two important European Court of Justice rulings (the 'SiMAP' and 'Jaeger' cases) have meant that currently working time includes all time spent at the place of work and available to the employer. This includes periods when the doctor is not actually working, for example resting during resident on-call periods.

Resident doctors should note that this definition differs from the contractual/New Deal classification of working time, which does not count all resident on-call hours as work, but makes a distinction between actual working hours and duty periods.

Further information

- Working Time Regulations 1998 www.legislation.gov.uk/ukxi/1998/1833/contents/made
 - The Working Time (Amendment No 2) Regulations 2009 www.legislation.gov.uk/ukxi/2009/2766/contents/made
 - See bma.org.uk/ewtd for extensive guidance including:
 - *The individual opt out: guidance for residents*
 - *Facing the challenges of the EWTD*
 - *The final countdown to the EWTD*
 - *The EWTD in practice: guidance for BMA members*
 - *Working patterns advice*
 - CEL 14 (2009) Working Time Regulation Compliance Guidance (Scotland), www.sehd.scot.nhs.uk/mels/CEL2009_14.pdf
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The resident doctors contract and the ‘New Deal’

Background and history

The New Deal is a package of measures designed to improve the conditions under which resident doctors work. It dates from 1991 and formed an agreement between representatives of resident doctors, consultants, the medical royal colleges, NHS managers and the Government. The New Deal continues to be relevant today because it underpins the resident doctors’ terms and conditions of service and pay banding system (see chapter 9). As a result, the terms ‘New Deal’ and ‘resident doctors contract’ are often used synonymously.

One of the key aims of the New Deal was the limiting of resident doctors’ working hours. Further areas covered by the New Deal included improvements to facilities such as catering and accommodation, and an examination of working practices with a view to transferring from resident doctors work which might be better undertaken by other healthcare professionals.

The interface between the New Deal and the EWTD

Both the New Deal and the EWTD apply simultaneously, and this can sometimes cause confusion. Compliance with both regulations can be achieved by following the least number of working hours and the most rest required. To put it another way, where there is variation between the conditions, the most favourable will apply (ie fewer hours, longer rest periods).

Confusion also creeps in when considering the definition of working time. Under the New Deal:

- ‘duty’ is counted as all time working or on-call, including rest while available
- hours of actual work are defined as all time spent on duty carrying out tasks for the employer, including any periods of formal study leave/teaching. This includes natural breaks.

However, as set out above, under the EWTD (the ‘SiMAP’ and ‘Jaeger’ cases):

- hours of duty and hours of actual work are treated the same, with all hours spent ‘at the disposal of the employer’ whether working or resting counting as working time for the purpose of the working hours restrictions.

This confusion can be cleared up by remembering:

- for matters of pay and banding the New Deal definitions apply
 - for compliance with the EWTD, the 'SIMAP'/Jaeger' definition applies.
-

New Deal contracted hours

The New Deal or resident doctors contract specifies the maximum number of duty hours for all resident doctors' posts as:

- 72 hours a week on on-call rotas on average
- 64 hours a week on partial shifts on average
- 56 hours a week on full shifts on average.

However, as explained above, the EWTD definition of working time means that in effect, doctors can work no more than 48 hours on average at the hospital per week.

These New Deal limits are a contractual requirement. Contracted hours should take into account routine early starts and late finishes, time off during the working day (eg half days) and, where applicable, prospective cover for annual and study leave.

New Deal controls on duty periods and rest requirements

In addition to the limits on contracted hours and hours worked, the New Deal lays down maximum periods of continuous duty, minimum periods of off duty between duty periods and minimum periods of continuous off duty for each type of working arrangement. These are as follows:

Working arrangement	Maximum continuous duty (hours)*	Minimum period off duty between duty periods (hours)*	Minimum continuous period off duty (hours)
Full shift	14	8	48 + 62 in 28 days
Partial shift	16	8	48 + 62 in 28 days
On-call rota	32 (56 at weekends)	12	48 + 62 in 21 days

* Except when two shifts are worked consecutively.

There is a limit on the maximum continuous duty days for all

working arrangements of 13 days.

Where the maximum periods of continuous duty, minimum periods of off duty between duty periods and minimum periods of continuous off duty differ to those set out in the EWTD the shorter of the duty hours and the longer of the periods between duty periods will prevail.

New Deal rest periods

The New Deal lays down the following periods of rest during duty periods:

On-call rotas: at least eight hours' rest during a period of 32 hours on duty, principally within the on-call period. Most of this should be continuous if possible.

Partial shifts: at least four hours of rest during every duty period of 16 hours.

Full shifts: all of the duty period, except for natural breaks, should be spent working or available for work.

Below is a table setting out the rest requirements for each working pattern as laid down in HSC 1998/240 (MEL(1999)40 in Scotland). The rest requirements apply equally to LTFT (less than full time) or flexible trainees as to full-time residents; the hours' limits should be adjusted pro rata. LTFT trainees should not be disadvantaged in terms of rest periods or work intensity.

The following factors should also be taken into account when assessing whether a working pattern fulfils the rest requirements:

- total rest within duty periods must not be made up of short interrupted periods of rest
- natural breaks must be provided during the normal working day for doctors on on-call rotas or partial shifts, as well as full shifts, and should be in addition to their rest periods
- at weekends, all duty periods are out of hours
- out-of-hours rest targets should be met during at least three-quarters of all duty periods.

Summary

Working pattern	Natural breaks	Minimum rest during the whole of each duty period	Minimum continuous rest guide	Timing of continuous rest
Full shift	Yes	Natural breaks	At least a 30-minute continuous break after approximately 4 hours continuous duty	At least a 30-minute continuous break after approximately 4 hours continuous duty
Partial shift	Yes	Natural breaks if no out-of-hours duty. Otherwise one quarter of the out-of-hours duty period*	Frequent short periods of rest are not acceptable	At any time during the duty period
24-hour partial shift	Yes	6 hours	4 hours	Between 10pm and 8am
On-call rotas	Yes	One half of the out-of- hours period**	Minimum 5 hours	Between 10pm and 8am

* eg 5pm–9am (Mon-Fri) = 4 hours or 9am–9pm (Sat/Sun) = 3 hours

** eg 5pm–9am (Mon-Fri) = 8 hours or 9am–9am (Sat/Sun) = 12 hours

Support for implementing the New Deal across the UK England

In England, regional improving resident doctors' working lives action teams or RATs (regional action teams) were established to be responsible for overseeing and monitoring the implementation of the New Deal at a local level and the allocation of posts into pay bands in accordance with the pay banding system. However, because of consecutive restructuring within the NHS, many regions now do not have RATs.

Scotland

In Scotland a Senior New Deal/WTR Adviser supports employers and employees on all aspects of the New Deal and Working Time Regulations (see the website www.newdealsupport-wp.scot.nhs.uk/). New Deal issues and current compliance levels are also discussed at regular meetings between representatives from the Scottish RDC, the Scottish Government and NHS Scotland employers.

Northern Ireland

In Northern Ireland the New Deal and EWTD is monitored by the NI HSC BLG (Health and Social Care Board) (formerly the Implementation Support Group (NI ISG)). The latter Group was set

up by the DHSSPS (Department of Health Social Services & Public Safety) in August 2001 to facilitate the implementation of the New Deal and the EWTD. NIRDC have been and continue to be actively involved in the work of the group and its subcommittees. The NIRDC Chairman meets regularly with the Medical Project Officer to scrutinise monitoring data and rotas to approve rebandings – no posts are rebanded without input with NIRDC.

Wales

In Wales, the New Deal and EWTD are monitored by the Welsh Government. A Monitoring Scrutiny Group has been established to scrutinise monitoring data and rotas and has produced all-Wales monitoring guidance. A member of WRDC and BMA Cymru Wales staff are members of the Group.

Posts which breach New Deal and/or EWTD limits

There are, unfortunately, posts in which doctors work in excess of New Deal and EWTD limits. Special provision within the pay banding system (see chapter 9) has been made to ensure that residents currently working the longest hours and/or the most frequent out-of-hours cover are remunerated the most. Nevertheless, resident doctors and their employers are contractually required to work together to identify appropriate working arrangements or other organisational changes in working practice which move non-compliant posts to compliant (for the purposes of both the New Deal and the EWTD), and residents are required to comply with reasonable changes following such discussion.

More commonly, many resident doctors are unable to get the amount of rest they require for their working pattern and thus work excess hours each week. If adequate rest is routinely not received during particular working periods, the employer should be informed and monitoring should be requested (see chapter 9 for further information).

Taking action to resolve New Deal and EWTD problems

Resident doctors should seek advice from their medical staffing department and contact our team of advisers via bma.org.uk/contactus in order to try to resolve problems with hours and/or rest. Ultimately, there are contractual penalties where posts breach New Deal limits. Enforcement of the EWTD for doctors is split between two main authorities.

The Health and Safety Executive have responsibility for dealing with complaints about hours limit breaches, while the employment tribunal system enforces the rest break and leave provisions. For more information see the BMA guidance at bma.org.uk/ewtd

Tips for resolving non-compliant rotas

While formal enforcement processes are available, the following should also be considered in any effort to resolve New Deal/EWTD problems:

Total hours

- It might be possible to reduce hours by redistributing workload.

Frequency of out-of-hours work

- The first step should be to identify what work is being done out of hours.

In both problem areas, the following might assist:

Bleep policies

- For example, filtering of calls by other practitioners, eg senior ward nurse; additional channelling through residents on full shift; no residents to be bleeped during organised training session.

Organisational changes

- Bringing more work back into daylight hours, eg emergency theatre lists, emergency admissions unit.
- Encouraging moves towards a consultant-delivered service. For example, evening ward rounds by consultants on-call can resolve many acute problems which might otherwise disturb residents at night. Consultants working in an identified admissions unit can provide an instant focus for clinical input.
- Avoiding duplication of tasks, eg multiple clerking of patients by different grades.
- Use of bed bureau to locate beds.

Skill mix initiatives

- Ensuring adequate staffing levels in support services, both daytime and out of hours.
- Sharing of tasks with other suitably trained staff, eg nurse practitioners.

Working to identify which tasks can be appropriately delivered by other staff. Possible examples include administration of IV drugs, carrying out requested investigations (bloods, ECGs, arranging X-rays etc), and catheterisation. There must also be mechanisms in place to ensure that, in the event of staffing pressures, these jobs do not default back to residents.

Reorganisation

- Increasing cross-cover of working patterns where appropriate so that, for example, doctors on a night shift may be able to relieve on-call doctors' workload.
- More team working.
- Possible merging of services between smaller units.
- Introduction of the 'Hospital at Night' model.

New working patterns

- When all the above have been implemented, and as long as there is an appropriate number of doctors on the rota to facilitate a working pattern change, some alternative form of working pattern may be investigated.

The RDC has produced detailed guidance on working patterns jointly with the Departments of Health and NHS Confederation. There is also RDC guidance on designing rotas and detailed BMA guidance on the practical implications of the EWTD. All EWTD guidance is available on the BMA website at bma.org.uk/ewtd

Further information

- HDL(2003)10 (Scot) Guidance on natural breaks
 - HDL(2005)21 (Scot) Managing New Deal non-compliance
 - *A guide to the implications of the EWTD for doctors in training*, Department of Health (2009) www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110100
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Pay banding and monitoring



9

Pay banding and monitoring

Summary

The banding system that determines resident doctor pay is explained in detail in this chapter for both full-time and LTFT (less-than-full-time) training. Underpinning the pay banding system are strict monitoring arrangements that must be followed by employers and resident doctors alike.

Only through monitoring can a rota's proper banding be determined or changed (rebanding). Where resident doctors dispute an employer's determination of banding they can appeal using a defined process explained in this chapter. Different types of working pattern are also defined and clarified here.

Pay banding

The resident doctors pay banding system has been in place since December 2000, and aims to remunerate resident doctors fairly according to the actual hours worked and the frequency of their out-of-hours work. A full-time resident doctor's contract consists of 40 hours of work plus such further contracted hours as are agreed with the employer including:

- all out-of-hours work
- agreed prospective cover for annual/study leave of colleagues
- any other regular commitments, eg early starts and late finishes
- any duty hours necessary for continuity of patient care.

However, as detailed in chapter 8, resident doctors' contracts and working arrangements are subject to the strict limits on total hours and minimum rest requirements imposed by both the EWTD and the New Deal. The pay bands reflect whether the post is compliant with the New Deal hours controls and rest periods, and also whether the doctor works up to 40, 48 or 56 hours a week, the type of working pattern, the frequency of out-of-hours duty and the unsocial nature of the working arrangements.

The pay banding system covers both full-time and part-time doctors and dentists in training, in posts and placements in the HCHS (Hospital and Community Health Service), including public health medicine trainees, but excluding GP trainees in posts in general practice. These posts or placements are in the training grades of F1 & F2, SpR, StR, StR(CT) and StR(FT) including locums in those grades (see chapter 13 for further details on locums).

How the system works

Full-time resident doctors

Every full-time resident doctor on national terms and conditions will be working on a rota that falls into either one of three pay bands or will be unbanded:

- **Band 3** includes all rotas that are not compliant with the New Deal's hours limits or rest requirements. These will be rotas that require more than 56 hours of actual work per week, or that do not deliver the required rest or natural breaks.

- **Band 2** includes all posts that are compliant with the New Deal and require over 48 hours of actual work and up to and including 56 hours per week.
- **Band 1** includes all rotas that are compliant with the New Deal and require between 40 and 48 hours of actual work per week.
- **Unbanded:** full-time doctors, whose entire working week consists of a maximum of 40 hours between 7am and 7pm, Monday to Friday, receive no additional supplement and their post is therefore not allocated to one of the pay bands.

Bands are subdivided on the basis of the amount of anti-social work. Band 2 is split into Bands 2A and 2B, and Band 1 is split into Bands 1A, 1B and 1C such that:

- **Bands 2A and 1A** include all rotas that, within their respective hours' limits, require the most frequent work at the most antisocial times, as defined by the banding criteria.
- **Bands 2B and 1B** include all rotas that, within their respective hours' limits, require less frequent and less anti-social out-of-hours work.
- **Band 1C** includes all rotas that require residents to work between 40 and 48 hours per week with a low frequency non-resident on-call pattern of work.

Total salary

The total salary of all resident doctors will comprise the basic salary (on the national incremental scale for each grade) plus a **banding supplement**, calculated as a percentage of the basic salary, according to the band to which the doctor's rota is allocated, as set out below. Figures in brackets show total salary expressed as a multiple of the full base salary:

Band	Percentage supplement (salary multiplier)
Band 3	100% (2.0)
Band 2A	80% (1.8)
Band 2B	50% (1.5)
Band 1A	50% (1.5)
Band 1B	40% (1.4)
Band 1C	20% (1.2)
Unbanded*	0% (1.0)

* This applies to doctors working on average 40 hours or fewer per week (unless training less than full time). Doctors in grade FHO1 only will receive a 5% uplift.

The DDRB is responsible for reviewing the value of the pay banding supplements annually and recommending changes accordingly. Any future changes to the value of pay bands will be posted on the BMA website.

Banding since August 2012

Since August 2012 no doctor should be working more than 48 hours a week taken over a six month average. This means that there should be no posts in band 2 or band 3 although some busy posts may slip into Band 3 through over-running shifts or missed rest.

No changes have been made to the value of banding supplements since 2002, but from 1 April 2010, all UK F1s with no out-of-hours work will receive a 5 per cent (1.05) banding supplement.

Further information

- Terms and conditions of service paras 18-22
 - Information on pay banding, including *Resident doctors guide to pay banding* available at bma.org.uk/practical-support-at-work/pay-fees-allowances/pay-banding
 - Pay Circulars for England: www.nhsemployers.org/your-workforce/pay-and-reward/pay/pay-and-conditions-circulars/medical-and-dental-pay-and-conditions-circulars
 - Pay Circulars for Scotland: [www.sehd.scot.nhs.uk/pcs/PCS2014\(DD\)01.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2014(DD)01.pdf) and www.msg.scot.nhs.uk/wp-content/uploads/PCSDD20141-Addendum.pdf
 - Pay Circulars for Northern Ireland TC8 9/2013: www.dhsspsni.gov.uk/hsc__tc8__9_2013_-_pay_and_conditions_of_service_for_hospital__medical_and_dental_staff_-_pay_award_2013.pdf and www.dhsspsni.gov.uk/index/hrd/guidance_circulars.htm
 - Pay Letters for Wales: www.wales.nhs.uk/nhswalesaboutus/workingforhswales/payconditions/payandconditionsresources
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LTFT or flexible trainees

Pay for LTFT trainees (resident doctors who work less than 40 hours of actual work per week) is calculated differently to full-time pay. However, as for full-timers, it is based on a system of pay bands. The current system has been in place since 2005 and was agreed between the RDC, NHS Employers, COPMeD and the Departments of Health with the aim of widening access to LTFT training.

Basic salary under this system is determined by the trainee's actual hours of work, and there is an additional banding supplement paid as a percentage of basic salary according to the frequency and anti-social nature of the trainee's out-of-hours work.

LTFT trainees' hours of actual work are divided into five discrete time categories and labelled F5-F9. Each category attracts a proportion of the full-time basic salary, as below:

- F5 is 20 or more, and less than 24, hours of actual work a week and attracts 0.5 or 50 per cent of full-time basic salary
- F6 is 24 or more, and less than 28, hours of actual work a week and attracts 0.6 or 60 per cent of the full-time basic salary
- F7 is 28 or more, and less than 32, hours of actual work a week and attracts 0.7 or 70 per cent of the full-time basic salary
- F8 is 32 or more, and less than 36, hours of actual work a week and attracts 0.8 or 80 per cent of the full-time basic salary
- F9 is 36 or more, and less than 40, hours of actual work a week and attracts 0.9 or 90 per cent of the full-time basic salary.

The banding supplement is calculated as a proportion of the calculated basic salary as below:

FA	50%
FB	40%
FC	20%

Total salary

Total salary for LTFT trainees is calculated as follows:

$$\text{Total salary} = \text{salary}^* + \text{salary}^* \left(\begin{array}{c} 0.5 \\ \times \\ 0.4 \\ 0.2 \end{array} \right)$$

* salary = F5 to F9 calculated as above.

The supplement for a LTFT post that is not compliant with the New Deal is applied at a rate of 100 per cent of the calculated basic salary. This is Band F3.

Flexible trainees who work less than 40 hours per week and perform no duty outside 7am to 7pm, Monday to Friday, receive no supplement.

Further information

- *Pay arrangements for flexible medical training* (2005) and *Principles underpinning the new arrangements for flexible training* (2005), available at www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/junior-doctors-dentists-gp-registrars/less-than-full-time-training
 - Information on flexible working available at bma.org.uk
 - PCS(DD)2005/7 LTFT training arrangements in Scotland: [www.sehd.scot.nhs.uk/pcs/PCS2005\(DD\)07.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2005(DD)07.pdf)
 - Terms and conditions of service, paras 21-22
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Supplements for on-call or out-of-hours work for medical academics

These should be paid by the substantive employer according to the amount of work undertaken in exactly the same way as for NHS doctors. The Follett Principles on joint working should mean that both employers work together to ensure the clinical academic is paid the total salary due and the reimbursement of monies owed to the substantive employer in respect of on-call/out-of-hours work undertaken in the NHS.

Definition of work and rest

Actual work: all time carrying out tasks for the employer, including periods of formal study/teaching. 'Actual work' does not include rest while on-call. For the purposes of defining work after 7pm, work begins when a doctor is disturbed from rest and ends when that rest is resumed. This includes, for example, time spent waiting to perform a clinical duty* and time spent giving advice on the telephone.

Rest: all time on duty when not performing or waiting to perform* a clinical or administrative task, and not undertaking a formal educational activity; but including time spent sleeping. **Natural**

breaks do not count as 'rest'. A natural break is at least 30 minutes continuous break after approximately every 4 hours on duty, without an interruption requiring you to do something. Under the New Deal, natural breaks count as 'work'.

* For example, a doctor waiting for the operating theatre to be prepared. 'Waiting to perform a clinical duty' does not include a doctor on duty who has been notified of a need to return to the hospital or unit, but not immediately; this period of time would count as rest.

Definition of weekend

A weekend worked is one that involves a doctor being on duty at any time during the period from 7pm Friday to 7am Monday.

Definition of out-of-hours work

The concept of out-of-hours is relevant for determining rest entitlements, and covers any time outside 9am to 5pm, Monday to Friday. (Note that unbanded posts can involve work that runs into these OOH periods, provided it remains within 7am to 7pm, Monday to Friday and to a maximum of 40 hours.)

Definition of working patterns

The type of working arrangement in place will have an effect on the rota's banding. While the following definitions apply under the resident doctors national contract (often referred to as the 'New Deal'), it is important to remember that the EWTD imposes different limits on the number of hours of continuous work and stipulates further rest periods in between (or requires compensatory rest to be given where prescribed rest is not achieved). **Where there is conflict, the shorter of the duty hours and longer of the rest periods between duty periods will prevail.** For further information on different working patterns see chapter 7.

On-call rota: doctors on on-call rotas usually work a set working day on weekdays, from Monday to Friday. The out-of-hours duty period is covered by doctors working 'on-call' in rotation. Residents are rostered for duty periods of more than 24 hours.

EWTD caveat: resident on-call rotas will be unlikely to be EWTD compliant.

Partial shift: on most weekdays doctors on partial shifts work a normal day. But, at intervals, one or more doctors will work a

different duty for a fixed period of time, eg evening or night shifts. Doctors can expect to work for a substantial proportion of the out-of-hours duty period, during which time they will expect to achieve some rest in addition to natural breaks. Residents will be rostered for duty periods of not more than 16 hours.

EWTD caveat: due to the requirement to achieve 11 hours rest in every 24 hours, periods of duty can only be resident if shifts are 13 hours or shorter (unless compensatory rest is given).

24-hour partial shift: weekdays are usually worked as normal days. In rotation, a duty period is rostered, not exceeding 24 hours including handovers, for the weekend and out-of-hours cover. Residents will be rostered for duty periods of more than 16 hours, but less than or equal to 24 hours.

EWTD caveat: periods of duty can only be resident provided shifts are 13 hours or shorter (unless compensatory rest is given).

Full shift: a full shift will divide the total working week into definitive time blocks with doctors rotating around the shift pattern. Doctors can expect to be working for the whole duty period, except for natural breaks. Residents will be rostered for duty periods that do not exceed 14 hours.

EWTD caveat: shifts must be no longer than 13 hours unless compensatory rest is given.

Hybrid working arrangement: a hybrid working pattern involves a combination of two or more of the above patterns (refer HSC 1998/240 Annex D, MEL(1999)40 Appendix D in Scotland). Each component duty pattern must conform to its appropriate definition and hours' controls as above.

Resident/non-resident on-call: a working pattern is defined as resident if it is carried out on site, ie at the hospital. A non-resident on-call duty period can be performed off site, eg from the practitioner's own home.

Definition of prospective cover

Prospective cover is in place when the doctor is contracted to provide internal cover for colleagues when they are on annual and/

or study leave, ie if no locums are provided. Prospective cover is also in operation when on-calls are required to be swapped when taking leave or when leave is fixed in advance. When a doctor on the rota acts as a 'floater', ie covering any doctors on the rota who are away on holiday, prospective cover is not in operation. More information on prospective cover is available in chapter 11.

Further information

- TCS para 19, 20 & 22k
 - *Guidance on working patterns for resident doctors*, Department of Health, National Assembly for Wales, NHS Confederation and the BMA (2002) http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009547
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Complex rotas and pay banding

All resident doctors who share the same rota and who work identical shifts should be assigned the same banding. Where resident doctors do not have identical duties and responsibilities to the others on the rota their working pattern should be assessed separately and they should be banded accordingly.

Pay banding supplements for GP specialty registrars

The supplements payable for GPStRs while in GP posts are as follows:

- 45 per cent for contracts made after 1 April 2009
- 50 per cent for contracts made between 1 April 2008 and 31 March 2009
- 55 per cent for contracts made between 1 April 2007 and 31 March 2008
- 65 per cent for contracts made before 1 April 2007.

For further information on pay and terms and conditions for GP specialty registrars, see *Framework for a written contract of employment: guidance for GP specialty registrars* (a separate framework is in place in Scotland where GP trainees are employed by NHS Education Scotland – see information available on the BMA website).

Pay banding for clinical academics and other resident doctors who work for more than one employer

Academics and other resident doctors who work for more than one employer will normally receive their base salary from their main employer. Where an academic or other resident doctor is working the same frequency of rota and/or length of hours as the NHS resident doctors in the rota, the same system will operate and the academic or other staff will receive the pay band supplement applicable to the rota in which they perform their out-of-hours duties. Where such doctors do not have identical duties and responsibilities to the rest of the doctors on their rota, they should be assessed separately taking into account the overall number of hours worked per week and frequency of out-of-hours work.

Resident doctors in academic posts should always hold either a substantive or honorary contract with an NHS employer while in training. For further information on pay and terms and conditions for resident clinical academics, see the *BMA Medical academic handbook* available on the BMA website.

Monitoring of work and rest

Employers are contractually obliged to monitor resident doctors' New Deal compliance and the application of the pay banding system. The individual doctor's contract also states that doctors too have an obligation to cooperate with monitoring arrangements. While a rota's theoretical banding can be determined 'on paper', it is only through monitoring that its formal banding can be confirmed. Monitoring therefore is absolutely vital in ensuring resident doctors are being paid properly for the work they do.

Monitoring:

- requires the collection of a variety of different data, including contracted hours, hours of duty and when those hours occur, hours of actual work and when those hours occur, and total and continuous rest periods
- should occur under representative conditions of work intensity (ie not at exceptionally quiet or busy periods, and not when many or no doctors are away on leave)
- should usually occur once every six months.

In Northern Ireland, the HSC Board Liaison Group has a policy which allows for consistently stable rotas to be moved to monitoring on annual rather than bi-annual basis. Any rotas put forward for consideration will be scrutinised closely by the Board Liaison Group prior to obtaining approval under the terms of the policy.

The monitoring process

Although monitoring is contractually required to confirm or determine the banding of a rota it may also, in many cases, serve to check EWTD compliance as well. A monitoring period of two weeks is usually sufficient but, to be more representative, it can be carried out over a longer period or over a cycle of the rota.

Hours information must use the agreed local recording methods (eg diary cards) and many employers now require resident doctors to supply monitoring information online.

The two main systems for recording hours online are DRS and Zircadian/Allocate. Each system has a different interface but with both systems it is important to ensure that you understand how they work so that you can record your hours accurately.

Employers should not require doctors to seek approval for working beyond their working hours, or explain why they were required to stay late. It can be useful to record reasons for shift overruns but this is not a requirement as part of the monitoring process and should not affect the validity of monitoring.

Further information:

- BMA information on monitoring systems: [bma.org.uk/monitoringguide](https://www.bma.org.uk/monitoringguide)
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If resident doctors have any concerns over their employers' monitoring processes, contact our team of advisers by visiting [bma.org.uk/contactus](https://www.bma.org.uk/contactus)

Before and after monitoring

Whichever system is in place, resident doctors should be notified well in advance of the monitoring period, they should be clearly advised of their obligations and have the opportunity to ask any

questions they feel necessary. They should be informed where to send the information recorded and how to get feedback on the outcome of their participation. Employers are obliged to publish the results of monitoring within 15 working days of the last day of the monitoring period. Hours should be recorded during the agreed monitoring period, preferably during or at the end of each duty period, rather than by less reliable methods. Where residents believe monitoring has taken place during an abnormal and unrepresentative period, they should request that their employers carry out a further round of monitoring.

A ‘valid’ monitoring round

Monitoring data must be provided by 75 per cent of the resident doctors on the rota and for 75 per cent of the shifts worked during the monitoring period. If the monitoring data submitted by resident doctors does not reach this threshold the monitoring round will be deemed invalid. A further period of monitoring must take place (see below).

When monitoring does not occur or is invalid

If monitoring does not occur, or is felt to be unrepresentative, this should be brought to the attention of the employer’s human resources department and contact our team of advisers via bma.org.uk/contactus

What should happen if employers fail to monitor?

Employers are contractually obliged to monitor. Arrangements for addressing any failure to do this vary across the UK so contact the BMA for advice if your employer is not monitoring properly.

What should happen if resident doctors fail to monitor?

If a resident or a group of residents fails, without good reason, to supply monitoring data, they should receive written notice from their human resources or medical staffing department reminding them of their contractual obligation to cooperate, and be required to participate in a further round of monitoring. Residents should be aware that persistent failure to comply with monitoring arrangements represents a breach of contract and may result in disciplinary procedures. If residents still fail to supply monitoring data, the employer can determine what it regards as the correct pay band, on the basis of the available information. It is essential, therefore, that resident doctors always cooperate with monitoring.

When monitoring reveals a different banding may be appropriate

If a monitoring period has been properly carried out using the employer's agreed procedure and analysis of the data calculates a different banding to the rota's existing formal banding, the employer is obliged to take action. If the analysis reveals a higher banding is appropriate, the employer should make arrangements to pay the resident doctors at the higher band until a further period of monitoring dictates otherwise. The employer may decide to reband the rota into the higher band (see the section on rebanding below) or they may decide to amend the rota to ensure the working pattern fits comfortably into the original banding. If the rota reveals a lower banding, the employer must continue to pay the current resident doctors at the original banding until they leave the rota. This is because the resident doctors contract operates a system of pay protection when bandings go down (see the section on pay protection below). The employer may decide to amend the rota formally while the doctors remain in post and/or reband the post, or they may wait until the doctors leave the rota and reband for the new staff.

Resident doctors are entitled to examine their employer's analysis of their monitoring data and dispute the results if they believe it has not been carried out correctly. Most employers use an analysis software package, but usually the methodology can be examined using the package's reporting mechanisms. Employers should not deny requests from resident doctors for analysis reports. BMA members should always contact the BMA for assistance and advice if they are in dispute with their employer over banding. There is a formal appeal mechanism within the contract for resident doctors to use in such instances (see the section on banding appeals below).

Fraud

Residents who knowingly and intentionally attempt to allocate their rota to a wrong band could face serious consequences. If residents intentionally complete monitoring forms inaccurately (eg to avoid a change to a different type of working pattern) they are denying all members of the rota, and their successors, the correct pay according to the banding allocation for their post. They are also letting their employer leave non-compliant working patterns unresolved. It is unacceptable for managers to pressure resident doctors into under-reporting their hours. If members experience this type of pressure they should contact the BMA for support.

Further information

- *Resident doctors hours – monitoring guidance*, Department of Health (2000) www.londondeanery.ac.uk/foundation-schools/policies-guidance-and-application-forms/general-documents-files/junior-doctors-hours-monitoring-guidance-dh.pdf
 - *Your guide to monitoring*, RDC (2010) bma.org.uk/monitoringguide
 - RDC guidance: Monitoring factsheet and monitoring FAQs bma.org.uk/monitoringguide
 - Template letters for resident doctors bma.org.uk/practical-support-at-work/contracts/junior-contracts/template-letters
 - *SRDC guide to monitoring* (2008) (Scot) at bma.org.uk
-

Rebanding

Since the pay banding system was introduced in 2000, employers have constantly needed to review and change working patterns for resident doctors in order to comply with New Deal and EWTD requirements. Even though the EWTD is now fully in force for all residents there will still be cause to redesign and change the banding of rotas on an ongoing basis. Any decisions to alter working patterns must not result in residents being told, with little or no notice, that their rotas will change and that they will be paid less as a result. This lack of notice is not allowed under the terms and conditions of service. Residents must always be involved in the planning of changes to their rotas.

The ‘rebanding protocol’

There are very specific rules about how a post’s banding can be changed. These are contained in the agreed ‘rebanding protocol’ available on both the Department of Health and BMA websites. An example of the rebanding ‘pro forma’ is also attached at Appendix 2. (See HDL(2002)33 for Scotland.)

A summary of the steps involved in rebanding a rota is listed in the table below. The pro forma lists all the steps and requires each one to be authorised through signing-off by all parties. If each step has not been signed off formally, the post will be deemed not to have been rebanded properly and the salary should remain at the previous level. The pro forma for Scotland can be found in circular HDL(2002)33.

If members have any concerns about proposed changes or pressure to agree to them, they should be raised with our team of advisers via bma.org.uk/contactus

The stages necessary to reband a training post

Stage	Evidence required	Documentation
1a Consult postholders on proposed changes and obtain agreement of the majority participating in the working arrangements*	Approval of majority of current/incoming postholders**	Template signed by employer resident doctor representative confirming agreement of majority of current/incoming postholders
1b Submit details of the new working arrangements to the action team for information and invited comment	Full details of proposed working arrangements and/or rota summary	Letter signed by action team chair or delegated authority confirming theoretical compliance of working arrangements
1c Obtain agreement from clinical tutor for education purposes.	Full details of proposed working arrangements Comments of action team	Letter signed by dean or delegated authority confirming educational acceptability of working arrangements

If exceptionally and because of the impracticality of full implementation of new working arrangements an employer wishes to offer future posts at an expected banding in advance of actual monitoring, approval must be sought from the regional action team or equivalent (as many parts of the UK do not now have RATs) in advance of making any such offer. Any offer made in these circumstances will be strictly provisional, and must be confirmed by monitoring following the implementation of new working arrangements.

2 Submit request for provisional approval of working arrangements to action team	Signed letter from employer giving reasons for inability to fully monitor before rebanding Evidence of full or partial testing/monitoring of proposed arrangements	Letter signed by action team chair or delegated authority authorising an offer of provisional banding
3 Monitoring of working pattern and confirmation of banding	Completed monitoring returns from 75 per cent of doctors on rota over full two-week period Summary of monitoring results	This signed template [Meaning whole pro forma as explained above table]

* The requirement for the resident doctors approval of changes does not permit demands to remain in Band 3 but does allow resident doctors to ensure the rota is workable and agreed by those concerned.

** Incoming postholders' includes anyone who knows they will be rotating into that post.

If changes are to be introduced at the change of postholders, agreement should be obtained from both outgoing and incoming doctors. A clear indication of the proposed change should be detailed in the job advertisement and job description. Before starting a new post, residents are advised to contact the previous postholders to clarify their current working arrangements, and then to check if they are being offered something different.

It should not be a condition of appointment that a prospective postholder agrees to a change resulting in him/her working longer hours than the present incumbent. If members have any concerns, they should seek advice from our team of advisers via bma.org.uk/contactus

Banding appeal process

If either the resident doctors or the employer disputes the results of the monitoring process, and/or if the rota's correct banding cannot be resolved, there is a right of appeal. It is the responsibility of the employer to operate the appeal process fairly and transparently. Appeals will be heard by a committee which must be convened by the employer as soon as possible and employers are expected to do so while the doctors remain in post. Appeals should be decided on the basis of the facts available, and the decision of the committee is final. The effect of the decision will be backdated to the date of the change in banding in question.

The BMA and NHS Employers have agreed a process for banding appeals to ensure that they run fairly and transparently and this is available at bma.org.uk/practical-support-at-work/pay-fees-allowances/pay-banding/tools-and-information

It is essential that members who are considering making an appeal contact our team of advisers via bma.org.uk/contactus for advice and support. Joint BMA/NHS Employers guidance clarifies the arrangements for banding appeals.

Backdating of pay on rebanding after monitoring

Where monitoring after a change of staff shows that a higher banding is appropriate, pay at the higher band will be backdated to the start of the post.

Where routine monitoring shows that a higher banding is appropriate, even though there has been no formal change to the working pattern, pay at the higher band will be backdated to the point three months after the first day of the previous valid monitoring round except:

- where this is the first monitoring round of the post, in which case pay is backdated to the first day in post; or
- where there have been intervening attempts by the employer to monitor but which have not been successful, in which case pay is backdated to the first day of the monitoring period that first showed a higher band was appropriate; or
- where valid monitoring at the request of the postholders showed a higher band, in which case pay is backdated to the date of the request to monitor if this is less than three months from the first day of the previous successful monitoring round
- where a previously non-compliant rota is shown on valid monitoring to fall into a compliant pay band, the employer must write to the doctors to inform them of the change, and pay at the protected level of Band 2A must be paid from the first day of the following month.

Rotational pay protection

The resident doctors contract includes a provision that allows residents to retain their higher pay if the rota on which they are working is rebanded to a lower band.

Current postholders will have their total salary* protected at the rate applicable at the time of rebanding for so long as it remains favourable and for the duration of the post/placement.

For rotations, future posts that have been formally accepted by the appointee and that are rebanded to a lower band shall have their salary* protected at the rate applicable at the time of rebanding as above. There are some differences in how the rebanding protocol applies across UK nations. Contact the BMA for more advice.

* Protected pay will be increased only to take account of increments in the base salary.

Further information

- TCS paras 21 & 22
 - RDC guidance: rebanding factsheet at [bma.org.uk/rebanding](https://www.bma.org.uk/rebanding)
 - HDL(2001)76 Resident doctor banding appeals arrangements (Scotland)
 - CEL17(2008) (Scot) Resident doctor banding appeals: good practice guidance for resident doctors and employers
 - *Resident doctor banding appeals: good practice guidance for resident doctors and employers*, NHS Employers and RDC: [bma.org.uk/practical-support-at-work/pay-fees-allowances/pay-banding/tools-and-information](https://www.bma.org.uk/practical-support-at-work/pay-fees-allowances/pay-banding/tools-and-information)
 - HSC Board Liaison Group: Monitoring guidance for resident doctors, monitoring outcome and banding appeals good practice guidance
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Indemnity

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Summary

It is essential for all doctors to ensure they have sufficient indemnity. This chapter provides a summary of the different types of indemnity and what is covered by these.

Indemnity

Medical indemnity

Since 1990 the NHS has had financial responsibility for negligence attributable to medical and dental staff of the hospital and community health services. Although it is not a contractual requirement for NHS employed doctors to hold indemnity insurance, such as that provided by the defence bodies, some work which does not fall strictly within the terms of the doctor's NHS contract is not covered by the NHS indemnity scheme and there may be occasions where there is a dispute about liability between the doctor and the employer.

Health service indemnity schemes in place across the UK provide support for clinical negligence claims, but not for disciplinary issues, or referrals to the General Medical Council, whereas the medical defence organisations do provide this level of support.

The BMA therefore advises all doctors to hold membership of a defence body or provide themselves with other personal indemnity insurance.

NHS indemnity

Further details of what is and is not covered by NHS indemnity are given below.

Work covered

- work which falls strictly under the doctor's contract with their employer (this includes where resident doctors work in independent hospitals as part of their NHS training, as a requirement under their NHS contract)
- foundation work in general practice
- family planning in hospitals
- hospital locum work (including through a locum agency)
- clinical trials authorised under the Medicines Act 1968 or subordinate legislation
- care of private patients in NHS hospitals where it is part of the resident's contract
- private practice carried out by resident clinical academic staff on the same basis as above

- work in a hospice if the doctor is seconded from a contract with an NHS employer
- work in a prison if part of the doctor's NHS contract.

Work not covered

- category 2 work (illustrations are listed in terms and conditions of service, paras 36 and 37), for example completing cremation certificates
- defence of medical staff in GMC disciplinary hearings, stopping at a roadside accident, or other 'good Samaritan' acts
- GP locum work
- GP registrars working in general practice in England, Northern Ireland and Wales (GP registrars working in Scotland are provided with indemnity but are contractually required to also maintain membership of a recognised medical defence organisation or insurer)
- clinical trials not covered under legislation
- work for other agencies on a contractual basis or for voluntary or charitable bodies
- work overseas
- work where a crime has been alleged.

Resident hospital doctors need separate cover if they undertake any category 2 work, which includes completing cremation certificates, examinations and/or reports on patients for courts, insurance companies, Department for Work and Pensions etc and making court appearances. For more information on category 2 fees see chapter 6. Private practice or work in independent hospitals which is not covered above also requires separate insurance.

Resident doctors who are required either by their employer or by their consultant to perform work which takes them over the hours limits set down in the New Deal and EWTD, would be covered by NHS indemnity and defence union cover.

Changing defence union

Doctors who are thinking of changing defence union should consider the wider implications of such a transfer, for example which union will provide cover for past events.

EWTD and medical indemnity

Many doctors have been concerned about the indemnity cover they will receive should they be asked or required to work outside the EWTD limits. While not wanting to encourage doctors to work over the EWTD limits the NHSLA (and the CNORIS (Clinical Negligence and Other Risk Scheme) in Scotland) has confirmed that it is conscious that working above these hours can be a feature of working life in the NHS. Medical Defence Organisations have no plans to change the cover they provide in light of the full implementation of EWTD.

A full statement regarding EWTD and indemnity is available on the BMA website at bma.org.uk/ewtd

Resident doctors and data protection

Resident doctors who make personal manual or electronic records of patient data, for example for training logbook purposes, should be aware of the provisions of the Data Protection Act 1998. If patient data are recorded on, for example, personal computers, and that data can identify a patient, then the data must be held subject to the provisions of the Data Protection Act. This would require the doctor to be registered for this purpose. Further information on the Act can be found on the Information Commissioner's website at <https://ico.org.uk/>

The Information Commissioner enforces and oversees the Data Protection Act 1998, and has a range of duties including the promotion of good information handling and the encouragement of codes of practice for data controllers, that is, anyone who decides how and why personal data (information about identifiable, living individuals) are processed.

The BMA advises resident doctors not to record data that identifies a patient, for example a patient's name, though data which can be matched to a patient only through use of a hospital record system or separate second data set is lawful on an unregistered computer. For example, a hospital number can only identify a patient if cross-referred with the hospital records system.

Further information

The MDDUS (Medical and Dental Defence Union of Scotland)

Mackintosh House,

120 Blythswood Street, Glasgow, G2 4EA

www.mddus.com

Tel: 0845 270 2034

info@mddus.com

The Medical Defence Union

MDU Services Limited

230 Blackfriars Road

London

SE1 8PJ

www.themdu.com

The Medical Protection Society

Medical Protection Society,


33 Cavendish Square, London

W1G 0PS

www.medicalprotection.org/uk/

Tel: 020 7399 1300

info@mps.org.uk



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Prospective
cover

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Summary

Many charged with implementing the New Deal have struggled with the concept of prospective cover. Although there is no nationally agreed means of calculating prospective cover, the RDC guidance is widely accepted and NHS Employers have confirmed that it is an accurate method of calculating such prospective cover.

Prospective cover

Below is a way of calculating hours of work devised by the BMA, which has replaced the old PCA (Prospective Cover Allowance) calculation.

Prospective cover

Employers may contract residents in advance to cover the full annual (including public holidays) and study leave entitlement of all colleagues on that rota. This is known as prospective cover. The residents on that roster are 'prospectively covering' the annual and/or study leave of their colleagues.

In practice, this means that a resident can normally only take annual or study leave on a day when he/she is rostered to work a normal day, otherwise the resident would be required to swap a shift or an out-of-hours duty period with a colleague on that rota in order to take leave. This practice is based on the assumption that only the proportion of work outside of the normal working day requires to be covered.

It is important to note, however, that this assumption may not hold for all shift- working patterns.

Prospective cover also applies when fixed leave is in operation on a rota (ie when residents are allocated set weeks leave in the rota).

When does prospective cover apply?

Prospective cover applies in all cases, except on those rotas where:

- locums are obtained to cover annual and study leave
- a resident can take annual or study leave at any time on the rota, including when rostered to be working out of hours (eg a late shift, over night or an on-call) and no resident on that rota is required to cover that shift.

Fixed leave

If *any* leave is fixed (eg annual leave or study leave) prospective cover applies.

Introduction of prospective cover

Prospective cover cannot be introduced into a resident doctor's existing contract without consent, or if the New Deal hours limits would be breached by doing so.

The TCS (Terms and Conditions of Service) state that if a change to a working pattern is likely to increase the number of hours worked (such as by introducing prospective cover) then the consent of the doctor must be obtained. The RDC interpretation of this is that the individual consent of each and every doctor must be obtained as the contract of employment (which is part of the TCS) does not refer to a group of doctors, only to individuals. Where the Band of a rota is likely to change as a result of a change to a rota the employer must seek the agreement of the majority of current/ incoming doctors. Any unilateral change without proper consultation must be resisted and reported to the BMA via bma.org.uk/contactus

Principle of prospective cover calculations

A resident doctor's working hours can fluctuate significantly from week to week. When annual or study leave is taken, a resident doctor's pay must take into account all the hours that they actually work when not on leave, rather than just those spent working normal days. This is especially important when prospective cover is in place.

When using the Riddell formula the following should be taken into account:

Annual leave entitlement

The basic annual leave entitlements for resident doctors are as follows:

F1	5 weeks
F2	5 weeks
Specialist/specialty registrar, specialty registrar (core training) and specialty registrar (fixed-term) (minimum, first or second incremental point)	5 weeks
Specialist/specialty registrar, specialty registrar (core training) and specialty registrar (fixed-term) (third or higher incremental point)	6 weeks

In addition full-time resident doctors are entitled to eight public holidays and two statutory holidays or days in lieu thereof each year.

(More information can be found in the section titled 'Annual leave'.)

Out-of-hours definition

Out-of-hours commitments are from 7pm to 7am. This can best be illustrated by an example:

A simple 1 in 8 full-shift rota is shown below.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Hours
1	Day	Day	Day	Off	Night	Night	Night	61.5
2	Off	Off	Off	Day	Day			16
3	Night	Night	Night	Night	Off			50
4	Day	Day	Day	Long	Day			44.5
5	Day	Day	Day	Day	Long	Long	Long	69.5
6	Day	Day	Long	Day	Day			44.5
7	Long	Long	Day	Day	Day			49
8	Day	Day	Day	Day	Day			40
							Total:	375
Shifts:	Day	0900-1700 8 hours						
	Long	0900-2130 12.5 hours						
	Night	2100-0930 12.5 hours						

For illustrative purposes, it is assumed in this example that each doctor is entitled to 6.5 weeks of leave each year (one week of leave in each eight-week rota cycle). Week eight contains no out-of-hours commitments. The residents on this rota are expected to take annual leave when they have no out of hours or swap their out-of-hours duties (ie they are prospectively covering their annual leave). Week eight also contains fewer hours than average.

On average, in the first seven weeks, the residents work:

$$\frac{61.5 + 16 + 50 + 44.5 + 69.5 + 44.5 + 49}{7} = 47.86 \text{ hours}$$

In this example, it's important that the resident doctors are not paid for 40 hours as their holiday entitlement, rather that the pay reflects the roughly 48 hours worked each week on average.

The Riddell formula for hours calculation©

Introduction

In conjunction with the BMA resident doctors committee, the Riddell formula was developed in 2002. The principle of the Riddell formula for hours calculation is outlined below. However, an understanding of this principle is not required to analyse a rota.

Principle of the Riddell formula

The Riddell formula identifies how many hours a doctor is working on average per week by dividing the number of hours a doctor works when not on leave by the number of weeks worked when not on leave, or:

$$\text{Average hours per week} = \frac{\text{total hours worked when not on leave}}{\text{weeks worked in rota cycle when not on leave}}$$

[Equation 1]

If we again consider our one in eight full-shift rota:

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Hours
1	Day	Day	Day	Off	Night	Night	Night	61.5
2	Off	Off	Off	Day	Day			16
3	Night	Night	Night	Night	Off			50
4	Day	Day	Day	Long	Day			44.5
5	Day	Day	Day	Day	Long	Long	Long	69.5
6	Day	Day	Long	Day	Day			44.5
7	Long	Long	Day	Day	Day			49
8	Leave	Leave	Leave	Leave	Leave			40
							Total:	375

The total hours worked when not on leave is the sum of hours total for weeks 1 to 7, thus:

$$\begin{aligned} &= 61.5 + 16 + 50 + 44.5 + 69.5 + 44.5 + 49 \\ &= 335 \end{aligned}$$

The number of weeks worked in rota cycle when not on leave is 7, thus:

$$\text{Average hours per week} = \frac{\text{total hours worked when not on leave}}{\text{weeks worked in rota cycle when not on leave}}$$

$$\begin{aligned} \text{Average hours per week} &= \frac{335}{7} \\ &= 47.86 \text{ hours} \end{aligned}$$

This is the same answer we derived in the previous calculation. We can therefore see that Equation (1) above allows accurate determination of average hours per week for our example full-shift rota. However, a formula is required to allow application to any rota type.

The formula can be expressed mathematically as:

$$\text{Average hours per week} = \frac{D - (E \times C)}{B - E}$$

- Where
- A = total leave entitlement for the year (in weeks)
 - B = number of weeks in the rota cycle (often equal to the number of doctors)
 - C = number of hours in a leave week (zero if all rostered shifts must be covered, irrespective of who is on leave)
 - D = total hours worked in the rota cycle if no leave is taken
 - E = $(A/52 \times B)$

This is the Riddell formula. To see its detailed derivation go to Appendix 3.

Use of the Riddell formula

As described, the Riddell formula identifies the number of hours a resident doctor is available for work on a given rota, ie the 'available hours'.* Therefore, the formula derives the available hours for a given rota, which can then be assessed against New Deal limits. For full-shift rotas, the 'available' hours and 'actual' hours will be the same on paper.

* The terms 'available hours' and 'duty hours' are often used interchangeably under the New Deal.

Determination of theoretical actual hours using the Riddell formula
The major reason to calculate theoretical actual hours of a rota is to determine the potential banding. Calculation of theoretical actual hours is not routinely required to determine New Deal compliance of a rota on paper. True actual hours will be determined on monitoring, and must not exceed the New Deal limit of 56 hours (or the limits imposed by the Working Time Regulations 1998).

The Riddell formula above derives the average 'available hours' per week for a given rota. 'Actual hours' may be determined either by substituting total actual hours worked in the rota cycle for variable D, or by subtracting rest from the total hours worked in the rota cycle (variable D). This latter approach allows identification of a formula, shown below, that will calculate actual hours for all rotas, including hybrid rota patterns.

$$\text{Average actual hours per week} = \frac{(D - \text{Rest}) - (E \times C)}{(B - E)}$$

- Where
- A = total leave entitlement for the year (in weeks)
 - B = number of weeks in the rota cycle (often equal to the number of doctors)
 - C = number of hours in a leave week (zero if all rostered shifts must be covered, irrespective of who is on leave)
 - D = total hours worked in the rota cycle if no leave is taken
 - E = $(A/52 \times B)$

Rest is defined as partial-shift rest requirements + on-call rest requirements + the number of 24-hour partial shifts x 6 hours (the rest requirement for a 24-hour partial shift). Thus:

$$\text{Rest} = \frac{F}{4} + \frac{G}{2} + [H \times 6]$$

- Where
- F = number of hours worked 'out of hours' in partial shifts (or total partial-shift hours if no normal working week day is identifiable)
 - G = number of hours spent on-call 'out of hours' in rotas involving on-call working arrangements (or total on-call shift hours if no normal working week day is identifiable)
 - H = the number of 24-hour partial shifts

The previous example rota is a full-shift working pattern, so all hours are considered actual work. The rest allocated to this rota therefore is zero.

Therefore:

$$\begin{aligned} \text{Average actual hours} &= \frac{(375 - 0) - \{(6.5/52 \times 8) \times 40\}}{8 - (6.5/52 \times 8)} \\ &= 40 \text{ hours} \end{aligned}$$

Determining a normal working weekday day

A normal working weekday can be identified in many rotas. This is the normal daytime shift that is worked Monday to Friday. In most rotas this is clear. If a normal working weekday day is not identifiable, it may be possible to determine times during which the residents are expected to be working at full-shift intensity during the week. This defines the 'in hours' period. If this is not identifiable then it may not be necessary to define a normal working day (for example in a full-shift pattern when all hours count as actual working hours). In this case, total partial shift or on-call hours should be used for variables F and G respectively.

Example of a rota without a normal working day

In this Emergency Medicine rota, there is no normal working day. Nights are worked at partial-shift intensity with all other duty periods being at full-shift intensity. The week marked as 'clinic/AL' is a supernumerary week where the individual is either on leave or receiving specialty training. Annual leave and public holidays are covered prospectively with all study leave covered by external locums. Therefore, there are 6.5 weeks of leave to cover per resident per year.

	Mon	Tues	Weds	Thurs	Fri	Sat	Sun	Available hours
1	Early 0900- 1600	Night 2100- 0900	Night 2100- 0900	Night 2100- 0900	Night 2100- 0900	Night 2100- 0900	Night 2100- 0900	79
2	Night 2100- 0900	Teaching 0900- 1030	Off	Off	Off	W/E Late 1100- 2300	W/E Late 1100- 2300	37.5
3	Off	Tues Early 0900- 2100	Late 1600- 2300	Middle 1100- 2100	Fri Early 0900- 2100	Off	Off	43
4	Middle 1100- 2100	Tues Late 0900- 2230	Early 0900- 1600	Late 1600- 2300	Off	W/E Early 0900- 2100	W/E Early 0900- 2100	63.5
5	Late 1600- 2300	Teaching 0900- 1030	Middle 1100- 2100	Early 0900- 1600	Fri Late 1600- 2300	–	–	39.5
6	Clinic/AL 0900- 1700	Clinic/AL 0900- 1700	Clinic/AL 0900- 1700	Clinic/AL 0900- 1700	Clinic/AL 0900- 1700	–	–	40
							Total hours	302.5

Applying the Riddell formula:

$$\begin{aligned} \text{Average available hours} &= \frac{302.5 - \{(6.5/52 \times 6) \times 40\}}{6 - (6.5/52 \times 6)} \\ &= 51.9 \text{ hours} \end{aligned}$$

To determine the 'actual hours' for the rota, we first determine the rest entitlement. The full-shift component of the rota requires natural breaks, which do not count towards rest, the partial-shift component accrues one quarter of the duty period as rest. Therefore, the total rest for this rota is equal to:

$$\begin{aligned} \text{Rest} &= \text{Total partial shift hours}/4 \\ &= (7 \times 12)/4 \\ &= 21\text{hrs} \end{aligned}$$

$$\begin{aligned} \text{Average actual hours} &= \frac{(302.5 - 21) - \{(6.5/52 \times 6) \times 40\}}{6 - (6.5/52 \times 6)} \\ &= 47.9 \text{ hours} \end{aligned}$$

Hours monitoring using the Riddell formula

How to determine the theoretical 'available' and 'actual' hours of a rota on paper has been described above. For banding purposes, the true average available and actual hours for a given rota must be determined by monitoring (see chapter 9 for full details on monitoring).

Analysis of monitoring forms is often complicated by lack of data. This occurs for two main reasons:

- the doctor is on annual leave
- the doctor has not completed a monitoring form.

It is essential to address this lack of data as outlined below. Failure to do so will result in an inaccurate result and may result in a post being inappropriately banded.

How to address annual leave in monitoring

Two problems can arise when monitoring a rota.

- 1) It is unlikely that the monitoring period will contain an absolutely representative amount of leave that would be expected on average to occur in a two-week period.

2) A worker is entitled to an average week as leave. However, many rotas often allocate shifts to an individual's 'leave' week if that resident has not gone on leave. These rarely equate to an average week. Therefore, we require a method that will standardise these two variable factors.

Firstly, a 'leave adjustment' is calculated from the rota template using the following formula:

$$\text{Leave adjustment} = \frac{(\text{average hours worked} - \text{allocated leave week in hours}) \times \text{leave entitlement}}{52}$$

This should be calculated twice (for all working patterns except full shifts), once for actual hours and once for available hours. The following examples help illustrate how this should be applied.

Example 1:

Taking an example five-week rolling on-call rota we can see how the formula should be applied to monitoring data.

	Mon	Tues	Weds	Thurs	Fri	Sat	Sun	Avail	Actual
1	On-call	Day	Day	Day	On-call	–	–	72	56
2	Day	Day	On-call	Day	Day	–	–	56	48
3	Day	On-call	Day	Day	Day	On-call	On-call	104	72
4	Day	Day	Day	On-call	Day	–	–	56	48
5	Day/AL	Day/AL	Day/AL	Day/AL	Day/AL	–	–	40	40
								328	264

Day = 9am to 5pm = 8hrs

On-call = 9am to 9am = 24 available hrs,

16 actual hours (weekend 12 actual hours)

Calculations show that on paper this rota requires the residents to be available for an average of 72 hours per week and to be actually working for an average of 56 hours per week.

This is on the basis that the doctors cover all their leave internally and achieve the minimum rest requirements under the New Deal. To adjust for leave during the monitoring period we can apply the following formula:

$$\text{Leave adjustment} = \frac{(\text{average week in hours} - \text{allocated leave week in hours}) \times \text{leave entitlement}}{52}$$

$$\begin{aligned} \text{'Available hours' leave adjustment} &= \frac{(72 - 40) \times 10.4}{52} \\ &= 6.4 \end{aligned}$$

$$\begin{aligned} \text{'Actual hours' leave adjustment} &= \frac{(56 - 40) \times 10.4}{52} \\ &= 3.2 \end{aligned}$$

Thus by providing internal cover, each doctor works on average an additional 6.4 available and 3.2 actual hours per week. These values must be added to the average hours determined during the monitoring exercise.

The leave adjustment must be added in all cases of monitoring, regardless of whether the monitoring included multiple or no doctors on leave.

In our example, we now monitor the post. When a doctor is on leave, we substitute in the rostered hours for the annual leave week, in this example $5 \times 8 \text{ hours} = 40 \text{ hours}$.

For each of the five doctors working this rota, their individual rotas for the two-week period will be as follows:

Doctor 1									
Week	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Avail	Actual
1	On-Call	Day	Day	Day	On-Call	–	–	72	56
2	Day	Day	On-Call	Day	Day	–	–	56	48
Doctor 2									
Week	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Avail	Actual
1	Day	Day	On-Call	Day	Day	–	–	56	48
2	Day	On-Call	Day	Day	Day	On-Call	On-Call	104	72
Doctor 3									
Week	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Avail	Actual
1	Day	On-Call	Day	Day	Day	On-Call	On-Call	104	72
2	Day	Day	Day	On-Call	Day	–	–	56	48
Doctor 4									
Week	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Avail	Actual
1	Day	Day	Day	On-Call	Day	–	–	56	48
2	Day/AL	Day/AL	Day/AL	Day/AL	Day/AL	–	–	40	40
Doctor 5									
Week	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Avail	Actual
1	Day/Al	Day/AL	Day/AL	Day/AL	Day/AL	–	–	40	40
2	On-Call	Day	Day	Day	On-Call	–	–	72	56

If for the monitoring exercise we obtained 100 per cent returns of monitoring forms, the individual residents adhere to start and finish times and achieve exactly the rest required under the New Deal, then their monitored and paper hours would be identical. Thus the total available hours on the basis of monitoring for this rota would be:

$$72 + 56 + 56 + 104 + 104 + 56 + 56 + 40 + 40 + 72 = 656$$

We now divide this number by the two weeks of monitoring and the five doctors to give an average of 65.6 available hours per week. However, this does not reflect the additional duties worked by providing internal cover. By adding the leave adjustment derived above we obtain the true average available hours for this rota:

$$65.6 + 6.4 = 72 \text{ hours}$$

By applying the same principle to the actual hours totals we get:

$$56 + 48 + 48 + 72 + 72 + 48 + 48 + 40 + 40 + 56 = 528$$

We now divide this number by the two weeks of monitoring and the five doctors to give an average of 52.8 actual hours per week. Adding the leave adjustment as above we obtain the true average actual hours for this rota:

$$52.8 + 3.2 = 56 \text{ hours}$$

This worked example demonstrates not only how to accurately account for annual leave in a monitoring period, but also that addition of the leave adjustment is required for accurate determination of monitored hours.

Example 2:

Using the previous eight-week full-shift rota as a second example.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Hours
1	Day	Day	Day	Off	Night	Night	Night	61.5
2	Off	Off	Off	Day	Day			16
3	Night	Night	Night	Night	Off			50
4	Day	Day	Day	Long	Day			44.5
5	Day	Day	Day	Day	Long	Long	Long	69.5
6	Day	Day	Long	Day	Day			44.5
7	Long	Long	Day	Day	Day			49
8	Leave	Leave	Leave	Leave	Leave			40
							Total:	375

To calculate the leave adjustment for this rota:

$$\begin{aligned}
 \text{'Actual hours' leave adjustment} &= \\
 & \quad (\text{average week in hours} - \text{allocated leave week in} \\
 & \quad \quad \text{hours}) \times \text{leave entitlement} \\
 & \quad \quad \quad \frac{52}{52} \\
 & = \frac{(47.86 - 40) \times 6.5}{52} \\
 & = 0.98 \text{ hours}
 \end{aligned}$$

By providing internal cover, each doctor works on average an additional 0.98 actual hours per week. This must be added to the average hours determined during the monitoring exercise to give the true average actual hours for the rota. If, as in the first worked example, all doctors returned monitoring forms and kept to their shift start and end times, the total number of hours worked during a two-week monitoring period would be 750 hours. Dividing this total number of monitored hours by two weeks and the number of doctors on the rota (eight), and adding leave adjustment figure of 0.98 hours gives:

$$\begin{aligned} &= 750/(2 \times 8) + 0.98 \\ &= 47.86 \text{ average actual hours} \end{aligned}$$

Non-returned forms

Resident doctors are contractually required to comply with monitoring. Employers are required to ensure that robust monitoring systems are in place. The contract states that a 'minimum return rate for monitoring is 75 per cent of all doctors in training on each rota... and 75 per cent of all duty periods'. If this is met, the hours not accounted for by non-returned forms must be accounted for in the assessment of monitoring data to ensure an accurate assessment of hours for banding. The missing data cannot be ignored because we may ignore a particularly quiet week, say 36 hours, which would artificially increase hours on monitoring and result in an inappropriately high band, and vice versa.

Therefore, providing the minimum return rate is met, any shifts unaccounted for should be added to the monitoring data as per the rostered hours. If the 75 per cent threshold is not met on either the percentage of doctors or percentage of shifts, the monitoring is invalid and must be repeated by the employer.

Less than full-time
(LTFT) training

12

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LTFT (less than full-time) training (previously known as flexible training)

Summary

This chapter explains what LTFT training is, the eligibility criteria for working LTFT, the application process, appealing decisions, the types of post available, and the information on how working LTFT may impact on your pension.

LTFT training allows doctors and dentists to work part time in posts that are fully recognised for training, and have the educational approval of the postgraduate dean and the royal colleges. This does not necessarily mean simply working half the time of a full-time trainee. Rather, LTFT trainees are able to train at 60 per cent, 70 per cent or 85 per cent of a full-time resident doctor, for example, as appropriate. In some specialties it is possible to work LTFT for the whole of postgraduate training, whereas others require some of this training to be full time.

All resident doctors are able to apply to train on a less than full time basis but applications are normally only considered if they have 'well-founded individual reasons' (EC Directive 93/16/EEC) such as domestic commitments, disability or ill health which prevent them from working full time. However, under the arrangements for LTFT training agreed in 2005, it is possible for resident doctors to seek LTFT training for a number of other reasons.

These include the undertaking of a particular religious role that requires a certain time commitment, training for a national/international sporting event or the holding of a short-term post with extraordinary responsibility. In practice it may not be possible to accommodate such requests and priority is normally given to those with caring responsibilities or ill health; however each application is reviewed on an individual basis.

Regardless of your reasons for wishing to train LTFT, it is the postgraduate dean, or associate dean with responsibility for LTFT training, who confirms that an application by a resident doctor to train LTFT is well founded. If you are interested in training LTFT, you should discuss this first with your deanery.

Further information

- SpRs should refer to '*A guide to specialist registrar training*' (the *Orange Book*)
 - [//webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4006614](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4006614)
 - StRs should refer to '*A reference guide for postgraduate specialty training in the UK*' (the *Gold Guide*) <http://specialtytraining.hee.nhs.uk/the-gold-guide/>
 - *Principles underpinning the new arrangements for flexible training* (2005) and *Equitable pay for flexible medical training* (2005), available at www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/junior-doctors-dentists-gp-registrars/less-than-full-time-training
 - PCS(DD)2005/7 LTFT training arrangements in Scotland: [www.sehd.scot.nhs.uk/pcs/PCS2005\(DD\)07.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2005(DD)07.pdf)
 - Northern Ireland TC81/05
-

Application process

To make the application process run as smoothly as possible there are a number of things that you need to consider in advance of your application.

- Determine how you fit into the categories and where possible and/or appropriate gather as much supporting evidence for your circumstances.
- Speak to other colleagues who work LTFT and ask them about their experiences (even if you are about to move deaneries).
- Find out how many hours they are contracted to work per week.
- Find out how they agreed their training programme to incorporate the full range of training opportunities available to full-time trainees? Perhaps they have worked one half of the week for six months and the other half for another six months.
- Find out what the full-time trainees do each week, eg proportion spent covering ward work, clinics, theatre, emergencies etc. Remember to include time for audit/protected teaching time/research etc.
- If you are applying through open competition and it is your first time applying for a LTFT training post, it may be hard for you to get all this information. Familiarise yourself with similar information in your current work place so you know what you

- should be looking for when you discuss your programme in your new role.
- Seek advice on eligibility from your associate postgraduate dean with a responsibility for LTFT training as to your eligibility. Find out who to contact by looking on your deanery website.

If you are told by your deanery that there are no spaces available, you should still request to receive any information they can send you and you should still submit your application. Contact our team of advisers for assistance via bma.org.uk/contactus

There are a number of steps to the application process and it can take up to three months. If you wish to train LTFT in a post, it is recommended that you start this process as soon as possible. The steps to take when applying are as follows.

1. Seek advice on eligibility from your associate postgraduate dean with a responsibility for LTFT training as to your eligibility. Find out who to contact by looking on your LETB/deanery website.
2. If you are not already working within the specialty or grade that you wish to train LTFT in you should apply through competitive entry to a full time post. If you are already in a full-time training post and wish to train LTFT within that same post you will not have to reapply for training.
3. Once your application for LTFT training has been accepted you need to agree your training programme with your LETB/deanery.
4. The Regional Specialty Education Committee or Training Programme Director will then obtain approval of the training programme on behalf of the dean and royal college.
5. Finally funding approval will be given by the deanery and the employer.

When applying for a training post, be reassured that it is not part of an appointment committee's job to consider whether a candidate wishes to train LTFT on taking up a post or in the future and candidates do not need to state in their application that they wish to train in this way. However, it is suggested that potential applicants discuss with the postgraduate deanery their intention to train LTFT at the earliest opportunity.

If your application to train LTFT is refused, you have the right to appeal this decision. You can also use this process if you are refused access to LTFT training, ie you are told you are not eligible to apply.

The appeals process should only be required on rare occasions as discussions with your LETB/deanery before applying should help inform you of whether you are eligible for LTFT training. Before starting the full appeals process you must first attempt to resolve issues informally by discussing your concerns with your deanery. You are allowed and encouraged to have a representative in these discussions and the BMA will provide support for members throughout the whole of the pre-appeals and appeals process. If the matter is resolved informally, this must be confirmed in writing. If not, then you are entitled to progress with the full appeals process.

Appeals are heard by an appeals panel who consider your application, your concerns and reasons for appeal in addition to the deanery's case. Then appeals panel will then make a final decision regarding your access to LTFT training.

In order to register your appeal you should follow these steps:

- submit your appeal in writing using the 'notification of appeal' form which is available from your LETB's/deanery's associate postgraduate dean with responsibility for LTFT training
- send a copy of the notification of appeal form to your postgraduate dean within 30 working days of the decision about which you are appealing
- send a copy of your notification of appeal form to the LTFT training administrator at your LETB/deanery.

More information on appealing a LTFT training decision is available on the BMA website bma.org.uk/flexibletraining

Types of LTFT training post

Deaneries now offer a number of different ways of incorporating LTFT training into rotas. There are three ways in which doctors can train LTFT; slot-sharing, supernumerary posts and job sharing.

Slot share

A training placement can be divided between two trainees, so that all duties of the full-time post are covered by two trainees. In a slot share two LTFT trainees are employed and paid as individuals (often for 60% or more) and work together. The two trainees share an educational post but not a contract and may overlap sessions.

Job-share

In job-share arrangements it is usual for two trainees to share a full-time salary, work half the hours and receive 50 per cent of the training opportunities.

Supernumerary post

Supernumerary posts can be offered when LTFT trainees cannot be placed in a slot- share because there is not a suitable partner or where LTFT training is needed at short notice. Supernumerary posts are additional to a normal complement of trainees and increasingly are only offered for those who require LTFT at short notice. Many deaneries no longer offer supernumerary posts as a standard form of training.

Information about postgraduate training is available from your local postgraduate dean's office. Usually one associate dean has a designated responsibility for LTFT training in the region.

Pensions for LTFT trainees

It should be noted that any less than full-time working is scaled down to its whole- time equivalent in calculating the pension payable. For more information please see chapter 18.

Further information

- BMA Less than full-time training guidance and experiences of LTFT doctors [bma.org.uk/flexibletraining](https://www.bma.org.uk/flexibletraining)
-

Locum work in the NHS

13

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Summary

This chapter provides information on locum work in the NHS and explains the terms and conditions of service for locum doctors directly employed by the NHS.

There are a number of issues to think about when considering working as a locum such as how this work relates to the New Deal, pay, and other terms and conditions of service such as annual leave, sick leave and notice periods.

Locum work in the NHS

Resident doctors employed on a locum basis in the NHS are subject to the terms and conditions of service for hospital medical and dental staff, unless they are employed directly by a locum agency. It is not possible to give advice on the terms which agencies may offer, as these vary between agencies. It should be noted that locum posts do not usually attract recognition for training except in certain circumstances. The situation should be ascertained before accepting a post.

Prospective cover and locum cover

Unless prospective cover arrangements are in place employers are obliged to obtain a locum to cover a resident doctor's annual and/or study leave. Locum cover must be organised to cover sick leave and maternity leave, except in emergencies as explained below. Employers should first try to arrange an external locum. Where this is not possible, and resident doctors agree to cover for colleagues as an internal locum, they should be paid according to the locum rates under the pay banding system.

Responsibility for arranging locum cover

It is the responsibility of the resident doctor to bring to the attention of the employer the need for locum cover. However, it is the responsibility of the employer to engage the locum.

Cover in emergencies

Your employer should not ask you to cover for absent colleagues on a long-term basis. However, there are specific circumstances where you may legitimately be asked to cover the 'occasional brief absence of colleagues' (as well as in exceptional emergency scenarios) and that 'sick colleagues will normally be covered only for short periods of absence', and we interpret this short period to be 48 hours in length. This would not apply to foreseeable short- or long-term rota gaps.

Such emergency cover should be recognised with either compensatory time off in lieu or with pay.

Lastly, academic trainees can be a special case as they may have additional commitments within the university or department and these should be protected and respected. This could also be the case with doctors with multiple employers.

If your situation is not covered here or you need more information, please contact our team of advisers for advice by visiting bma.org.uk/contactus

Further information

- Terms and conditions of service, para 110
-

Locums and the New Deal

Resident doctors may only be employed on a locum basis by their own employers provided that such employment does not cause their average weekly hours to exceed the limits in the New Deal, except in circumstances where they are acting up as a consultant.

It is a contractual term that resident doctors should not undertake locum medical or dental work for any other employer where such work would cause their contracted hours to breach the New Deal limits.

Further information

- Terms and conditions of service, para 111a-b
-

External locums

External locums engaged through an agency are paid according to the rate negotiated by the agency; employers are allowed to negotiate locally the best arrangements for their particular circumstances. There is a national procurement contract for the supply of temporary agency locum doctors in Scotland governing the agreed pay and commission rates for agency locums.

External locums engaged directly by employers for a week or less are paid in accordance with the locum rates agreed under the pay banding system.

In all cases, the rate is that appropriate to the grade of the doctor being covered (not the locum's own grade).

Internal locums

Resident doctors employed on an internal locum basis in the NHS are subject to the Terms and Conditions of service for hospital medical and dental staff.

Under internal locum arrangements, employers pay resident doctors providing locum cover in their own hospitals, or associated hospitals identified in the job description, at locum rates agreed for the pay banding system for the whole time they are on duty, provided that such work is undertaken when the doctor would otherwise have been off duty. If cover is being provided outside the doctor's main hospital, external locum arrangements apply.

Internal locum arrangements, unlike prospective cover arrangements, allow doctors to be paid at the locum rate of the grade of the doctor being covered. The hours can be claimed at the locum rate, or if the doctor wishes, leave may be taken in lieu. For doctors working in England, Wales & Northern Ireland then it is possible to negotiate rates through local agreement. We would strongly advise that members seek advice from our team of advisers before agreeing to a locally negotiated rate. Our advisers can be contacted via bma.org.uk/contactus

When a resident doctor performs work on a locum basis for their employer, and the agreement of the employer is not secured in advance, the resident should claim payment at locum rates. Employers should designate a person responsible for authorising retrospective payments and ensure that the doctor is paid as quickly as possible.

Further information

– Terms and conditions of service, paras 111a-e

Part-time locums

A resident doctor engaged as a locum for less than 40 standard hours per week without a regular appointment is paid on the same basis as internal or external locums above.

Locum pay

Under the pay banding system, locums are paid on the following basis:

Band LA

For locums employed to cover a shift working pattern, hours outside Monday to Friday, 9am to 5pm, are paid at the following rate:

- 1.8 x basic hourly rate

Band LB

For locums employed to cover an on-call rota, hours outside Monday to Friday, 9am to 5pm, are paid at the following rate:

- 1.5 x basic hourly rate

Band LC

For locums employed on any working pattern, all hours within Monday to Friday, 9am to 5pm, are paid at the following rate:

- 1.4 x basic hourly rate

Band LL

For locums employed to cover a post for one week or more are paid at the following rate:

- 1.2 x total salary (basic salary + banding supplement) of the post being covered

For specialty registrars, there are two basic hourly rates that such locums may be paid, the StR lower rate and StR higher rate. The lower rate is payable when the locum is covering a doctor working at levels ST1 or ST2. In all other cases, the higher rate is applicable.

For all other grades, the mid-point of the grade salary scale is the basic hourly rate.

LATs (locum appointments for training)

Resident doctors in LATs are excluded from the pay arrangement detailed above. Doctors in LAT posts are paid at the incremental point to which they are entitled because of previous experience, not the mid-point.

Other terms and conditions of service

Locums are entitled to the same terms and conditions of service as regular appointments except in the following areas:

Notice periods

Locums are not entitled to the minimum periods of notice for regular appointments. An employer is required by statute to give a minimum of one week's notice to terminate the employment of a locum who has been employed for at least four weeks.

Annual leave

Resident doctors acting as locums are entitled to leave at the rate of five or six weeks per 12 months' continuous locum service, depending on the grade being covered. 'Continuous locum service' means service as a locum in the employment of one or more employer uninterrupted by the tenure of a regular appointment or by more than two weeks during which the resident doctor was not employed in the hospital service.

Wherever possible, leave should be taken during the occupancy of the post. If this is not possible, leave may be carried forward to the next succeeding appointment, or payment in lieu of leave earned and not taken may be made. In practice, the latter is more common.

Sick leave

Although the sick leave provisions of the terms and conditions of service apply to locums, a locum contract cannot be extended to cover sickness that continues after the contract has expired.

Travelling expenses

Where a locum travels between their place of residence and their hospital, travelling expenses are paid in respect of any distance by which the journey exceeds 10 miles each way. Where a locum takes up temporary accommodation at or near the hospital, the initial and final journeys are paid.

The specialist registrar and specialty registrar grades

When vacancies arise in the specialist and specialty registrar grades, two types of appointment can be made:

- a locum appointment covering the service element of the post only (LAS)
- a locum appointment which not only covers the service element but which provides a training opportunity (LAT).

Further details of all of these can be found in 'A guide to specialist registrar training for specialist registrars' (also known as the Orange Guide) http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4006614 and 'A guide to postgraduate specialty training in the UK' (also known as the Gold Guide) <http://specialtytraining.hee.nhs.uk/the-gold-guide/> for specialty registrars.

Advice is available to members from our team of advisers by visiting bma.org.uk/contactus

Further information

- Terms and conditions of service, paras 117, 211-13, 241 and 289 CEL 16 (2013) – Scotland National Governance and standards for Supplementary Medical Staff: www.sehd.scot.nhs.uk/mels/CEL2013_16.pdf
-

16,000
resident doctors
turn to us each year
on employment
issues

Simply view our guidance to check if your contract conforms to the agreed national model before you sign.

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Study and professional leave

14

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Summary

This chapter covers resident doctors' entitlements to time off and expenses for study leave and explains what can be done if problems are encountered.

Study and professional leave

Study or professional leave is granted for postgraduate education or teaching purposes, and includes study (usually, but not exclusively or necessarily, on a course), research, teaching, examining or taking examinations, visiting clinics and attending professional conferences.

Although entitlement to study leave is outlined in the terms and conditions of service, there are currently many variations in study leave implementation across the UK. The granting of funding, time off and approval for study leave can depend on a resident doctor's location and can vary between specialties.

The following information provides details on how to get more information on applying for study leave.

Definition of study leave

Study leave is available for specific educational and training needs, which cannot be obtained through the training programme.

Study leave is typically (but not exclusively) granted to include study on a course, research, teaching, examining, visiting clinics and attending professional conferences. Funding for study leave ensures that doctors continue to be paid for the time spent absent from their place of work. With prior agreement, reasonable expenses incurred by the trainee for approved study leave should also be reimbursed by the deanery.

Study leave and reimbursement of related expenses will be granted at the discretion of the LETB or Local Education Provider (in England) or deanery .

Entitlement

Foundation year 1

Foundation doctors in year 1 are not contractually entitled to take formal study leave. However, the FTPD (foundation training programme director) should ensure access to a formal taught programme of education that addresses the professional elements of the curriculum. F1s should have up to three hours per week of protected, bleep-free time set aside for a timetabled learning programme. Alternatively, this time may be aggregated to give seven days of whole day release.

In Scotland there is an understanding that from 1 April in foundation year 1, F1s can 'borrow' up to five days study leave from their F2 allocation in order to complete a taster period prior to applying for specialty training. In other parts of the UK there should be similar arrangements, according to the UK foundation programme office *Guidance on specialty tasters for foundation trainees* www.foundationprogramme.nhs.uk/pages/home

Foundation year 2

In F2, doctors are eligible for 30 days study leave per year. Their contractual entitlement is exactly the same as for specialty trainees (see below). However, a minimum of 10 days of their study leave will be used for a formal educational programme in generic professional training and other aspects of F2 training. Study leave can also be used to complete taster periods – there may be local guidance around this. For example, in Scotland up to 10 days study leave can be used for tasters, with a maximum of five days in any four-month block.

The terms and conditions of service recommend the following standards on entry to specialty training:

Specialty training (including FTSTAs)

Either:

- day release for the equivalent of one day per week during university terms; or
- up to a maximum of 30 days in a year; and
- study leave to sit an examination for a higher qualification where it is necessary as part of a structured training programme (up to two occasions); and
- study leave to sit other examinations for a higher qualification (discretionary).

In addition, the *Gold Guide* states that:

- 1) trainees must be made aware of how to apply for study leave and be guided as to what courses would be appropriate and what funding is available
- 2) trainees must be able to take study leave up to the maximum permitted in their terms and conditions of service
- 3) the process for applying for study leave must be fair and transparent, and information about a deanery-level appeals process must be readily available.

Less than full-time trainees

Less than full-time trainees are eligible for study leave.

Medical academic doctors

Study, sabbatical and other leave are determined by the substantive employer, and will be agreed in consultation with the NHS where there may be an impact on clinical services.

Applications

The administration of how you can access the funding and time off for study leave varies between LETBs/deaneries. When starting a training programme, resident doctors should check the deanery's policy on study leave (in Scotland, NHS Education for Scotland has published a national study leave policy). Regional postgraduate deans (or NHS Education for Scotland) have overall responsibility for managing study leave budgets.

However, in most regions budgets have been devolved to clinical tutors (training programme directors in Scotland, postgraduate deans in Northern Ireland and postgraduate organisers in Wales) or the appropriate NHS employer. Applications are usually required to be submitted locally before the leave is taken and all expenses that are likely to be incurred should be indicated on the application. The study leave application will normally require the approval of the resident doctor's consultant or clinical director.

It is not the responsibility of the resident doctor to find or arrange any locum cover during the study leave period. Resident doctors should contact the human resources department to find out the procedure for applying for study leave in their hospital.

Details about applying for study leave in Scotland can be found at the following link: www.nes.scot.nhs.uk/education-and-training/by-discipline/medicine/help-and-support/study-leave.aspx

Details about applying for study leave in Wales can be found on the Deanery website at: www.walesdeanery.org/index.php/en/deanery/postgraduate-education-support-services/postgraduate-centres/1334-welcome-to-the-pg-centres-homepage.html

In Northern Ireland, hospital training study leave guidance can be found on the NIMDTA (NI Medical and Dental Training Agency) website at www.nimdtg.gov.uk/hospital-medicine/study-leave/

Expenses

Employers should accept the natural consequences of granting study leave, so that all reasonable expenses associated with periods of approved study leave are paid. However, there are circumstances where this could be unreasonable, for example, where expenses are met wholly or partly by a sponsoring body or where a doctor holds a contract with more than one employer.

In deciding what are 'reasonable expenses' employers have been told by the Department of Health that 'it would not, in our view, be reasonable for an authority to pre-determine a given level of expenses which it was prepared to approve in connection with applications for study leave'. In other words, when employers grant study leave, they must grant pay and expenses.

Where study leave expenses are granted, the full rates of travel and subsistence set by the GWC should be paid. Examination fees are not paid.

Some deaneries/LETBs also put a limit on the study leave budget allowed for each resident. For the reasons stated in the above paragraph, the RDC regards this as inappropriate.

Professional leave for overseas conferences etc

Employers may at their discretion grant professional or study leave outside the UK with or without pay and with or without expenses or with any proportion thereof.

Accommodating time off for study leave

Study leave will normally be granted to trainees as long as essential hospital services are maintained in accordance with the recommended standards.

The terms and conditions of service also indicate that a rota should have a sufficient number of doctors working on it so that prospective cover can be provided for each other's study leave. However, if a system of prospective cover is not in place, employers should find locums to cover resident doctors' study leave requirements.

The BMA strongly advises resident doctors to get involved with rota planning. As study leave will normally be agreed a minimum of four to six weeks in advance, it should be able to be incorporated into the rota. If study leave is not granted because of rota shortages or poor rota design, this should be raised with the clinical tutor or director of medical education.

Appeals

If study leave is refused or granted without pay or expenses, resident doctors can take the following steps.

- (i) Appeal to the regional study leave committee (if one exists). This is a regional committee, on which resident doctors are represented, whose job it is 'to ensure consistent and uniform practices and to decide appeals'. If there is no study leave committee in your region you should contact your postgraduate dean. Further details of the local study leave policy may be also obtained from the postgraduate dean. It is important that resident doctors do appeal because referral of refused applications will not otherwise occur.
- (ii) Small claims court (or Sheriff Court in Scotland). If study leave is granted but without pay and/or expenses, the matter may be pursued through the small claims court as long as the claim is under £5,000 (£3,000 in Scotland). Hearings are usually in private and less formal than proceedings in higher courts. However, it is possible for a case to be referred, by the registrar hearing the case, to the full County court. Costs may then be payable.

(iii) Employer's grievance procedure. In cases where pre-determined policies are being arbitrarily imposed, it may be worth appealing to the employer under the grievance procedure.

In Scotland, the appeal procedure is outlined in the study leave operational guide, which can be found at www.nes.scot.nhs.uk/education-and-training/by-discipline/medicine/resources/policies.aspx

BMA members should seek advice from our team of advisers via bma.org.uk/contactus before embarking on an appeal.

Study leave for GP trainees

The GP trainees subcommittee of the GPC has agreed policy on study leave for GP registrars. The guidance note *Study leave for GP registrars* is available on the BMA website bma.org.uk/practical-support-at-work/contracts/leave/leave-gp-trainees

Further information

- The entitlement to study leave is paras 250-53 in the terms and conditions of service. More information on study leave can be found in the following resources:
- Rough guide to foundation programme – for all foundation year 1 and foundation year 2 trainees. www.foundationprogramme.nhs.uk/pages/home/keydocs
- 'A reference guide for postgraduate specialty training in the UK' or the *Gold Guide* – All specialty trainees or StRs (including general practice trainees, those in core training, LTFT training and trainees in academic programmes) should refer to the *Gold Guide*. <http://specialtytraining.hee.nhs.uk/the-gold-guide/>
- 'The guide to specialist training' or the *Orange Book* – SpRs (specialist registrars), SpTs (Specialist Trainees in Public Health Medicine) and GPRs (General Practice Registrars), whose training programme started before August 2007, should refer to the *Orange Book*.
- [://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4006614](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4006614)

- UK Foundation Programme Office Guidance on specialty tasters for foundation trainees www.foundationprogramme.nhs.uk/pages/home/keydocs
 - In Northern Ireland study leave guidelines for hospital trainees can be found on the NIMDTA (Northern Ireland Medical and Dental Training Agency) website www.nimdtta.gov.uk/hospital-medicine/study-leave/
 - NHS Education for Scotland study leave policy: www.nes.scot.nhs.uk/education-and-training/by-discipline/medicine/help-and-support/study-leave.aspx
 - Wales Deanery study leave policy: www.walesdeanery.org/index.php/en/deanery/postgraduate-education-support-services/postgraduate-centres/1334-welcome-to-the-pg-centres-homepage.html
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Annual leave

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Annual leave

Summary

This chapter explains the basic annual leave entitlements for resident doctors and how to calculate annual leave entitlements. The chapter also details public holiday entitlements, what to do if you become sick while on annual leave and the inclusion of fixed leave in your rota.

Basic entitlement

The basic annual leave entitlements for resident doctors are as follows.

F1	Five weeks
F2	Five weeks
Specialist/specialty registrar, specialty registrar (core training) and specialty registrar (fixed-term) (minimum, first or second incremental point)	Five weeks
Specialist/specialty registrar, specialty registrar (core training) and specialty registrar (fixed-term) (third or higher incremental point)	Six weeks

Calculating annual leave entitlement

As resident doctors work more than a standard working week, there has always been confusion as to what constitutes a week's leave in terms of number of days off. This has led to employers adopting different ways of calculating annual leave entitlements with employers calculating annual leave on the basis of a five, six or seven-day working week.

Leave taken in complete weeks

When annual leave is taken in complete weeks, one week should be any period of seven consecutive days. This would include weekends, whether or not there is an on-call commitment.

Leave taken in odd days

When annual leave is taken in periods of one or more days, which do not correspond to complete weeks, the entitlement needs to be expressed in days. The recommended standard formula is as follows:

$$\text{weeks' leave} \times \text{week length}$$

where the weeks' leave are five or six depending on grade, and the week length is the average number of days of the week on which there is a contractual commitment irrespective of the duration or type of commitment on any particular day.

Examples

1. A FO is entitled to five weeks' annual leave. A FO on a 1 in 4 rota would have a weekly commitment of five days (Monday to Friday) plus two weekend days divided by the number on the rota (ie $2 \div 4 = 0.5$ days).

This FO's average weekly contractual commitment is therefore 5.5 days. The FO's annual leave entitlement is therefore:
 $5 \times 5.5 \text{ days} = 27.5 \text{ days pa}$

2. A specialty registrar is entitled to six weeks' annual leave. A specialty registrar on a 1 in 4 rota would therefore have an annual leave entitlement of:
 $6 \times 5.5 \text{ days} = 33 \text{ days pa}$

The formula can also be applied to resident doctors working on a partial- or full-shift system.

However, there are several other methods found in different hospitals, each of which has its advantages and disadvantages.

- The five-day week. A complete week counts as five days, making the annual leave entitlement 25 or 30 days (depending on grade); weekdays including Fridays count as one day. Taking less than full weeks in this system may sometimes give a lower allowance than the recommended formula and should be brought to the attention of our team of advisers via bma.org.uk/contact
- The six- or seven-day week. A complete week counts as six or seven days, making the annual leave entitlement between 30 and 42 days depending on grade.

This is usually achieved by counting Fridays as two or three days, the rationale being that this prevents the potential abuse of taking a large number of Fridays combined with requesting not to be on-call at the weekend.

Further information

- Terms and conditions of service, paras 205-17
 - GWC handbook sections 1 and 2
-

Daytime work cover

Some departments engage locums for daytime work, some expect residents of the same grade to cover, some expect residents of different grades on the same firm to cover, and some have 'floating' residents. Whichever method is used, resident doctors should ensure that they do not feel exploited or overworked by their colleagues' absence. If this is the case, members should consult our team of advisers via bma.org.uk/contactus

Leave year

The leave year for all doctors in the training grades runs from each doctor's incremental date.

For foundation doctors the leave period corresponds to the period of tenure of the post, and not more than four days' leave may be carried forward from one post to subsequent appointments.

Untaken leave

Where a resident doctor has been unable to take the full allowance of annual leave before the end of the 'leave year' they are allowed to carry over up to five days, subject to the exigencies of the service and authorisation from the employer. Employers often restrict leave such that only one doctor per rota can be on leave at any one time. If resident doctors wait until the end of the post to take leave, they may not be able to take it. In general it is more beneficial to take the leave than to be paid in lieu, since payment in lieu for a day's leave is normally made at only 1/31 of a month's salary.

Transferring leave from post to post

Carry over of leave from one post to another is often contentious, and should be agreed in advance with the new employer. Foundation doctors may only transfer up to four days' leave. The terms and conditions of service states that: 'The leave period of an F1 or HO shall correspond with the period of tenure of a post'. Normally this will mean that the total annual leave allowance of five weeks will be divided between each individual post in the F1 year. An F1 cannot then carry forward more than four days of that allocation into the next four-month post. The previous employer is responsible for notifying the next employer about the outstanding leave, although it is prudent to check that this has been done.

Notification of leave

Resident doctors are required to notify their employer when they wish to take leave, and the granting of such leave is subject to approved arrangements having been made for cover. It is usual for employers to ask for a minimum period of six weeks' notice of intention to take leave.

Fixed leave

Some employers have introduced planned leave arrangements in order to make it easier for them to provide locum or prospective cover. These arrangements are not well-liked but in some circumstances can be to the advantage of all resident doctors on a rota or shift. However, such schemes must be applied in a reasonable manner and command the support of the resident doctors locally.

As a resident doctor you are entitled to annual leave of between five and six weeks depending on your level of seniority. Most rotas are designed with 'leave weeks' built in; that is weeks where the resident doctor is on a week of normal day shifts, with no out-of-hours commitment. These weeks allow flexibility in planning annual leave as these weeks can be swapped with other resident doctors on the rota with their agreement. You can still take leave in other weeks, but this will require swapping out of the on-call/out-of-hours commitments with your colleagues. Another approach used by employers is to design a rota template with periods of annual leave factored in – resident doctors are then either allocated to a slot or given the choice of a slot which suits their leave needs. This approach is much less flexible for the resident doctors. This is often referred to as fixed leave.

Sickness during annual leave

If a resident doctor falls sick during annual leave and produces a statement to that effect at the time, (eg a self-certificate) the resident doctor should be regarded as being on sick leave from the date of the statement. Where the first statement is a self-certificate, that statement should cover the first and any subsequent days up to and including the seventh day of sickness. Medical statements should be submitted to cover the eighth and subsequent calendar days of sickness where appropriate. Further annual leave should be suspended from the date of the first statement.

Public holidays

Full-time resident doctors are entitled to eight paid statutory and public holidays each year as follows: New Year's Day, Good Friday, Easter Monday, May Day, Spring Bank Holiday, Late Summer Holiday, Christmas Day and 26 December. A further two days, known previously as statutory (or 'stat') days, are available. These may either be specified by the employer or converted into annual leave. This applies to both England and Wales.

In Scotland, the statutory days consist of three public holidays at Christmas/New Year, with the remainder as determined by the employer in the light of local practice.

In Northern Ireland full-time employees are entitled to 12 paid statutory and public holidays per year. Christmas Day, 26 December, New Years Day, St Patrick's day, Easter Monday, Easter Tuesday, May Day, Spring Bank Holiday, 12 July, Late Summer Holiday and the further two 'statutory days'.

Part-time resident doctors are usually entitled to statutory and public holidays on a pro rata basis, although different arrangements may apply locally.

Working on public holidays

If a resident doctor is required to be on duty at any time, including between midnight and 9am on a statutory or public holiday they should receive a day off in lieu. If the resident doctor is required to continue working the normal day it may be possible to negotiate an additional day off in lieu. If it is not feasible to take these days in lieu, then pay in lieu can be given.

Further information

- GWC handbook sections 1 and 2
http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Advancedletters/DH_4071871
 - Terms and conditions of service, para 214
-

Public holidays and zero hour days

'Zero-hour' days cannot be double-counted as public holidays. Where resident doctors are on a rota to do a zero-hour day on a public holiday, they should receive a day in lieu.

Annual leave for locums

Information on annual leave for locums is available in the 'locums' section of the handbook (see chapter 13).

Prospective cover

Information on prospective cover is available in chapter 11 of the handbook.

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Maternity,
paternity and
shared parental
leave

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Maternity, paternity and shared parental leave

Summary

This chapter provides a summary of the eligibility criteria for maternity and paternity leave and provides details of how they are calculated. Information is also provided on maternity pay and the contractual and training rights when on maternity leave.

Following the birth of a child, the rights to paternity leave and pay give eligible employees the right to take paid leave to care for the child or support the mother. There is a NHS scheme and a statutory scheme. New legislation regarding shared parental leave allows both parents to take leave concurrently or sequentially.

Eligibility

An employee working full time or part time will be entitled to paid and unpaid maternity leave under the NHS contractual maternity pay scheme if:

- she has 12 months’ continuous service with one or more NHS employers at the beginning of the 11th week before the EWC (expected week of childbirth)
- she notifies her employer in writing before the end of the 15th week before the expected date of childbirth (or if this is not possible, as soon as is reasonably practicable thereafter) of her intention to take maternity leave and of the date she wishes to start her maternity leave; and that she intends to return to work with the same or another NHS employer for a minimum period of three months after her maternity leave has ended
- and provides a MATB1 form from her midwife or GP giving the expected date of childbirth.

Changing the maternity leave start date

If the employee subsequently wants to change the date from which she wishes her leave to start she should notify her employer at least 28 days beforehand (or, if this is not possible, as soon as is reasonably practicable beforehand).

Confirming maternity leave and pay

Following discussion with the employee, the employer should confirm in writing:

- the employee’s paid and unpaid leave entitlements under this agreement (or statutory entitlements if the employee does not qualify under this agreement)
- unless an earlier return date has been given by the employee, her expected return date based on her 52 weeks’ paid and unpaid leave entitlement under this agreement; and
- the length of any period of accrued annual leave and accrued leave for public holidays which it has been agreed may be taken following the end of the formal maternity leave period
- the need for the employee to give at least 28 days’ notice if she wishes to return to work before the expected return date.

Keeping in touch

Before going on leave, the employer and the employee should also discuss and agree any voluntary arrangements for keeping in touch during the employee's maternity leave including:

- any voluntary arrangements that the employee may find helpful to help her keep in touch with developments at work and, nearer the time of her return, to help facilitate her return to work
- keeping the employer informed of any developments that may affect her intended date of return.

Keeping in touch (KIT) days

KIT days have been introduced to help make it easier for employees when it is time to return to work after a period of maternity leave.

KIT days may be used for training or other activities that enable the employee to keep in touch with the workplace. However, they are not compulsory and any such work must be by agreement and neither the employer nor the employee can insist upon them. An employee may work for up to a maximum of 10 KIT days, **excluding the first two weeks of compulsory maternity leave immediately after the birth of the baby**, without bringing her maternity leave to an end. Any days of work will not extend the maternity leave period, but will be paid at the employee's basic daily rate for the hours worked, less appropriate maternity leave payments.

Paid maternity leave

Amount of pay

Where an employee intends to return to work the amount of contractual maternity pay receivable is as follows:

- for the first eight weeks of absence, the employee will receive full pay, less any SMP (statutory maternity pay) or MA (maternity allowance) (including any dependants allowances) receivable
- for the next 18 weeks, the employee will receive half of full pay plus any SMP or MA (including any dependants allowances) receivable providing the total receivable does not exceed full pay
- for the next 13 weeks, the employee will receive any SMP or MA that they are entitled to under the statutory scheme.

By prior agreement with the employer this entitlement may be paid in a different way, for example a combination of full pay and half pay or a fixed amount spread equally over the maternity leave period.

Calculation of maternity pay

Full pay will be calculated using the average weekly earnings rules used for calculating SMP entitlements, subject to the following qualifications.

- In the event of a pay award or annual increment being implemented before the paid maternity leave period begins, the maternity pay should be calculated as though the pay award or annual increment had effect throughout the entire SMP calculation period. If such a pay award was agreed retrospectively, the maternity pay should be re-calculated on the same basis.
- In the event of a pay award or annual increment being implemented during the paid maternity leave period, the maternity pay due from the date of the pay award or annual increment should be increased accordingly. If such a pay award was agreed retrospectively, the maternity pay should be re-calculated on the same basis.
- In the case of an employee on unpaid sick absence or on sick absence attracting half pay during the whole or part of the period used for calculating average weekly earnings in accordance with the earnings rules for SMP purposes, average weekly earnings for the period of sick absence shall be calculated on the basis of notional full sick pay.

Unpaid contractual maternity leave

Employees will also be entitled to a further 13 weeks' unpaid leave, bringing the total leave to 52 weeks.

Commencement and duration of leave

An employee may begin her maternity leave at any time between the 11th week before the expected week of childbirth and the expected week of childbirth provided she gives the required notice.

Sickness prior to childbirth

If an employee is off work ill, or becomes ill, with a pregnancy-related illness during the last four weeks before the expected week of childbirth, maternity leave will normally commence at the beginning of the fourth week before the expected week of childbirth or the beginning of the next week after the employee last worked whichever is the later. Absence prior to the last four weeks before the expected week of childbirth, supported by a medical statement of incapacity for work, or a self-certificate,

shall be treated as sick leave in accordance with normal sick leave provisions. Where sickness absence is unrelated to pregnancy the normal sickness provisions will apply up until the date notified for the start of maternity leave.

Odd days of pregnancy-related illness during this period may be disregarded if the employee wishes to continue working until the maternity leave start date previously notified to the employer.

Pre-term birth

Where an employee's baby is born alive prematurely the employee will be entitled to the same amount of maternity leave and pay as if her baby was born at full term.

Where an employee's baby is born before the 11th week before the expected week of childbirth, and the employee has worked during the actual week of childbirth, maternity leave will start on the first day of the employee's absence.

Where an employee's baby is born before the 11th week before the expected week of childbirth, and the employee has been absent from work on certified sickness absence during the actual week of childbirth, maternity leave will start the day after the day of the birth.

Where an employee's baby is born before the 11th week before the expected week of childbirth and the baby is in hospital the employee may split her maternity leave entitlement, taking a minimum period of two weeks' leave immediately after childbirth and the rest of her leave following her baby's discharge from hospital.

Still birth

Where an employee's baby is born dead after the 24th week of pregnancy the employee will be entitled to the same amount of maternity leave and pay as if her baby was born alive.

Miscarriage

Where an employee has a miscarriage before the 25th week of pregnancy normal sick leave provisions will apply as necessary.

Health and safety of employees pre- and post-birth

Where an employee is pregnant, has recently given birth or is breastfeeding, the employer should carry out a risk assessment of her working conditions. If it is found, or a medical practitioner considers, that an employee or her child would be at risk were she to continue with her normal duties the employer should provide suitable alternative work for which the employee will receive her normal rate of pay. Where it is not reasonably practicable to offer suitable alternative work the employee should be suspended on full pay.

These provisions also apply to an employee who is breastfeeding if it is found that her normal duties would prevent her from successfully breastfeeding her child.

Return to work

An employee who intends to return to work at the end of her full maternity leave will not be required to give any further notification to the employer, although if she wishes to return early she must give at least 28 days' notice.

An employee has the right to return to her job under her original contract and on no less favourable terms and conditions.

Returning on flexible working arrangements

If at the end of maternity leave the employee wishes to return to work on different hours the NHS employer has a duty to facilitate this wherever possible, with the employee returning to work on different hours in the same job. If this is not possible the employer must provide written, objectively justifiable reasons for this and the employee should return to their original contractor to a post at the same grade and work of a similar nature and status to that which they held prior to their maternity absence.

If it is agreed that the employee will return to work on a flexible basis, including changed or reduced hours, for an agreed temporary period this will not affect the employee's right to return to her job under her original contract at the end of the agreed period.

Sickness following the end of maternity leave

In the event of illness following the date the employee was due to return to work normal sick leave provisions will apply as necessary.

Failure to return to work

If an employee who has notified her employer of her intention to return to work for the same or a different NHS employer in accordance with the regulations fails to do so within 15 months of the beginning of her maternity leave she will be liable to refund the whole of her maternity pay, less any SMP, received. **If there is no right of return to be exercised because the contract would have ended if pregnancy and childbirth had not occurred the repayment provisions set out above will not apply.** In cases where the employer considers that to enforce this provision would cause undue hardship or distress the employer will have the discretion to waive their rights to recovery.

Employees not returning to NHS employment

An employee who satisfies the required eligibility conditions but who does not intend to return to work with the same or another NHS employer for a minimum period of three months after her maternity leave is ended, will be entitled to pay equivalent to SMP, which is paid at 90 per cent of her average weekly earnings for the first six weeks of her maternity leave and to a flat rate sum for the following 33 weeks.

Employees with less than 12 months' continuous service

If an employee does not satisfy the eligibility conditions for contractual maternity pay she may still be entitled to SMP. SMP will be paid regardless of whether she satisfies the eligibility conditions above. If her earnings are too low for her to qualify for SMP, or she does not qualify for another reason, she should be advised to claim MA from her local Job Centre Plus or social security office.

Fixed-term contracts or training contracts

Employees subject to fixed-term or training contracts which expire after the 11th week before the expected week of childbirth, and who satisfy the required conditions, shall have their contracts extended so as to allow them to receive the 52 weeks, which includes paid contractual and statutory maternity leave and the remaining 13 weeks of unpaid maternity leave.

Absence on maternity leave (paid and unpaid) up to 52 weeks before a further NHS appointment shall not constitute a break in service. Employees on fixed-term contracts who do not meet the 12 months' continuous service condition set out above may still be entitled to SMP.

Rotational training contracts

Where an employee is on a planned rotation of appointments with one or more NHS employers as part of an agreed programme of training, she shall have the right to return to work in the same post or in the next planned post irrespective of whether the contract would otherwise have ended if pregnancy and childbirth had not occurred. In such circumstances the employee's contract will be extended to enable the doctor to complete the agreed programme of training.

Contractual rights

During maternity leave (both paid and unpaid) an employee retains all of her contractual rights except remuneration.

Increments

Maternity leave, whether paid or unpaid, shall count as service for annual increments and for the purposes of any service qualification period for additional annual leave.

Accrual of annual leave and public holidays

Annual leave will accrue during maternity leave, whether paid or unpaid. Where the amount of accrued annual leave would exceed normal carry over provisions, it may be mutually beneficial to both the employer and employee for the employee to take annual leave before and/or after the formal (paid and unpaid) maternity leave period. The amount of annual leave to be taken in this way, or carried over, should be discussed and agreed between the employee and the employer.

Public holidays will also accrue during maternity leave.

Pensions

Pension rights and contributions shall be dealt with in accordance with the provisions of the NHS Superannuation Regulations.

Ante-natal care

Pregnant employees have the right to paid time off for ante-natal care. Ante-natal care may include relaxation and parentcraft classes as well as appointments for ante-natal care.

Post-natal care and breastfeeding mothers

Women who have recently given birth should have the right to paid time off for post-natal care. Employers are required to undertake a risk assessment and to provide breastfeeding women with suitable private rest facilities, and should consider requests for flexible working arrangements to support breastfeeding women at work.

Continuous service

For the purposes of calculating whether the employee meets the 12 months' continuous service with one or more NHS employers qualification set out above, the following provisions shall apply:

- NHS employers includes health authorities, NHS Boards, NHS Trusts, primary care organisations and the Northern Ireland Health Service
- a break in service of three months or less will be disregarded (though not count as service).

The following breaks in service will also be disregarded (though not count as service):

- employment under the terms of an honorary contract
- employment as a locum with a GP (general practitioner) for a period not exceeding 12 months
- a period of up to 12 months spent abroad as part of a definite programme of postgraduate training on the advice of the postgraduate dean or college or faculty adviser in the speciality concerned
- a period of voluntary service overseas with a recognised international relief organisation for a period of 12 months which may exceptionally be extended for 12 months at the discretion of the employer which recruits the employee on her return
- absence on an employment break scheme in accordance with the provisions of the hospital terms and conditions of service
- absence on maternity leave (paid or unpaid) as provided for above.

If your break in service is not covered by the list above but spans a period approved as an OOPE (Out of Programme Experience for

Clinical Experience), it may also be possible to have it disregarded. If you are in this situation, contact the BMA for advice.

Employment as a trainee with a general medical practitioner in accordance with the provisions of the Trainee Practitioner Scheme shall similarly be disregarded and will count as service.

Employers have the discretion to count other previous NHS service or service with other employers, and to extend the periods specified above.

University or honorary contracts

Doctors holding university and NHS honorary contracts will be subject to the maternity leave scheme that is in operation at their place of employment. A university contract, with or without an NHS honorary contract, does not count as continuous service under the NHS maternity scheme. However, where an employee has a university contract with an NHS honorary contract this period of employment will not constitute a break in service although it cannot be counted towards service for the purposes of further maternity leave.

Further information

- Further guidance on maternity leave and pay, including the NHS Employers guide for residents doctors, can be found on the BMA website [bma.org.uk/workingparents](https://www.bma.org.uk/workingparents)

Unfair dismissal

Regardless of length of service or hours of work it is unlawful for an employer to dismiss an employee or to select her for redundancy, solely or mainly because she is pregnant or has given birth, or for any other reason connected with her pregnancy or childbirth.

If you feel that you are being denied your employment rights contact our team of advisers via [bma.org.uk/contactus](https://www.bma.org.uk/contactus) in the first instance. They will assess your circumstances and where necessary arrange for local representation.

Defence body subscriptions

Doctors who take maternity leave should contact their defence body as special beneficial arrangements should apply.

Paternity leave

NHS scheme

The scheme applies equally to biological and adoptive fathers, nominated carers and same-sex partners.

Eligibility

Employees must have 12 months' continuous service with one or more NHS employers at the beginning of the week in which the baby is due in order to qualify for the NHS paternity leave scheme. More favourable local arrangements may be agreed with staff representatives and/or may be already in place.

Benefits

There will be an entitlement to two weeks' occupational paternity leave at full pay (less any statutory paternity pay receivable) per birth. SPP should only be deducted if the employee is eligible to receive it (see below).

Full pay will be calculated on the basis of the average weekly earnings rules used for calculating occupational maternity pay entitlements. Only one period of occupational paternity pay is ordinarily available when there is a multiple birth. However, NHS organisations have scope for agreeing more favourable arrangements where they consider it necessary or further periods of unpaid leave.

Local arrangements should specify the period during which leave can be taken and whether it must be taken in a continuous block or may be split up over a specific period.

An employee must give his or her employer a completed form SC3 'Becoming a parent' at least 28 days before they want leave to start. The employer should accept later notification if there is good reason.

Paternity leave

Reasonable paid time off to attend ante-natal classes will also be given.

Those with insufficient NHS service to qualify for the occupational scheme will still be entitled to 2 weeks unpaid maternity support leave and may qualify for the statutory scheme.

Statutory scheme

Eligibility

Employees must satisfy the following conditions in order to qualify for paternity leave. They must:

- have or expect to have responsibility for the child’s upbringing
- be the biological father of the child and/or the husband or partner of the mother
- have worked continuously for the same employer for 26 weeks ending with the
- 15th week before the baby is due, or employed up to and including the week your wife, partner or civil partner was matched with a child for adoption.
- must be earning an average of the lower earnings limit a week (before tax).

Employers can ask their employees to provide a self-certificate form SC3 (becoming a parent) as evidence that they meet these eligibility conditions.

Length of paternity leave

Eligible employees can choose to take either one week or two consecutive weeks paternity leave (not odd days). They can choose to start their leave:

- from the date of the child’s birth (whether this is earlier or later than expected); or
- from a chosen number of days or weeks after the date of the child’s birth (whether this is earlier or later than expected); or
- from a chosen date later than the first day of the week in which the baby is expected to be born. Leave can start on any day of the week on or following the child’s birth but must be completed:
 - within 56 days of the actual date of birth of child; or
 - if the child is born early, within the period of the actual date of birth up to 56 days after the expected week of birth.

Only one period of leave is available to employees irrespective of whether more than one child is born as the result of the same pregnancy.

Statutory paternity pay

During their paternity leave, most employees are entitled to statutory paternity pay (SPP) from their employers.

SPP is paid by employers for either one or two consecutive weeks as the employee has chosen. The rate of SPP is the same as the standard rate of SMP.

Notice of intention to take statutory paternity leave

Employees must inform their employers of their intention to take paternity leave by the end of the 15th week before the baby is expected, unless this is not reasonably practicable. They must tell their employers:

- the expected week the baby is due
- whether they wish to take one or two weeks' leave
- when they want their leave to start.

Employees can change their mind about the date on which they want their leave to start providing they tell their employer at least 28 days in advance (unless this is not reasonably practicable). Employees must tell their employers the date that they expect any payments of SPP to start at least 28 days in advance, unless this is not reasonably practicable.

Self-certificate

Employees must give their employers a completed self-certificate as evidence of their entitlement to SPP. A model self-certificate for employers and employees to use is available on the BIS website. Employers can also request a completed self-certificate as evidence of entitlement to paternity leave. The self-certificate must include a declaration that the employee meets certain eligibility conditions and provide the information specified above as part of the notice requirements.

By providing a completed self-certificate, employees will be able to satisfy both the notice and evidence conditions for paternity leave and pay. Employers will not be expected to carry out any further checks.

Contractual benefits

Employees are entitled to the benefit of their normal terms and conditions of employment, except for terms relating to wages or salary (unless their contract of employment provides otherwise), throughout their paternity leave. However, most employees will be entitled to SPP for this period. If the employee has a contractual right to paternity leave as well as the statutory right, he may take

advantage of whichever is the more favourable. Any paternity pay to which he has a contractual right reduces the amount of SPP to which he is entitled.

Return to work after paternity leave

Employees are entitled to return to the same job following paternity leave.

Protection from detriment and dismissal

Employees are protected from suffering unfair treatment or dismissal for taking, or seeking to take paternity leave. Employees who believe that they have been treated unfairly can complain to an employment tribunal.

Employers recovery of payments

Employers can recover the amount of SPP they pay out in the same way as they can claim back SMP. Employers can claim back 92 per cent of the payments they make, with those eligible for small employers relief able to claim back 100 per cent plus an additional amount in compensation for the employers portion of national insurance contributions paid on SPP.

Additional paternity leave and pay will no longer be available for babies due after 5 April. This has been replaced by shared parental leave (see below).

Further information

- Further guidance on paternity leave can be found on the BMA website: [bma.org.uk/practical-support-at-work/working-parents/thinking-of-having-a-baby/paternity-leave](https://www.bma.org.uk/practical-support-at-work/working-parents/thinking-of-having-a-baby/paternity-leave)
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Shared parental leave

In April 2015 the UK government introduced new legislation governing SPL (shared parental leave). This legislation allows SPL for two people who share care of a child (parent, husband, wife, civil partner, joint adopter or partner of the parent if they live with the parent and child) and allows them to share any untaken maternity leave (two weeks maternity leave is required after the birth) up to a maximum of 50 weeks. SPL can only be taken between the birth and first birthday (or the date of adoption and one year later). An overlap of

maternity leave and SPL (of the other partner) is permitted but only if 8 weeks' notice of the end of maternity leave has been provided.

There are a number of eligibility criteria which can be viewed on the Department of Health webpage (www.gov.uk/shared-parental-leave-and-pay/overview).

SPL can be taken at different times or overlapped with the partner but the total combined leave cannot exceed the duration of any remaining maternity leave. Both parents are able to work 20 days each during SPL.

Statutory SPL pay is at the same rate as maternity pay.

Further information

- Further guidance on shared parental leave can be found at www.gov.uk/shared-parental-leave-and-pay/overview
www.acas.org.uk/index.aspx?articleid=4911
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‘Most resident doctors have little knowledge of their rights or the law and even if they do, they don’t want to cause a fuss. But having a contract is absolutely vital to ensure you are protected.’

Specialty registrar, London

Simply view our guidance to check if your contract conforms to the agreed national model before you sign.

We can help you be as prepared as you possibly can at this vital stage in your career.

Visit bma.org.uk/yourcontract

Sick leave

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Summary

This chapter provides details on sick leave allowances, including the scale of the allowance, the calculation of allowances, notification of sickness and statutory sick pay.

Sick leave

References are made throughout this section to paragraphs in the GWC (General Whitley Council) conditions of service, which is still in use.

Further information

- Terms and conditions of service, paras 225-44
 - GWC handbook section 57
-

Scale of allowance

Resident doctors absent from duty owing to illness, injury or other disability receive the following sick leave allowances.

During the first year of service	one month's full pay and (after completing four months' service) two months' half pay
During the second year of service	two months' full pay and two months' half pay
During the third year of service	four months' full pay and four months' half pay
During the fourth and fifth years of service	five months' full pay and five months' half pay
After completing five years of service	six months' full pay and six months' half pay

For resident doctors sick pay should include the banding supplement.

Employers can extend these allowances in exceptional cases. Because these periods are relatively short, resident doctors should also seek independent financial advice on income protection.

Calculation of allowances

The amount of sick leave allowance and the period for which it is to be paid are worked out by taking the resident doctor's sick leave entitlement as on the first day of sickness and subtracting the total sick leave taken in the 12 months prior to the current absence. When calculating total periods of absence, days taken as unpaid sick leave are not counted towards the final figure. Specific conditions apply to absence due to injury resulting from a violent crime. For the purposes of calculation of the allowance, 26 working days are equivalent to 'one month'.

Previous qualifying service

All previous NHS service, (including locum service), university, local authority or civil service employment without any break of more than 12 months, is aggregated for sick leave purposes. There are several exceptional circumstances in which a break of more than 12 months does not mean a break in previous qualifying service. Where a resident doctor has broken their regular service in order to go overseas on a rotational appointment, or on an appointment which is considered by the postgraduate dean or college or faculty adviser in the specialty concerned (if necessary, with the advice of the consultant) to be part of a suitable programme of training, or to undertake voluntary service, their previous NHS or other approved service should be taken fully into account in assessing entitlement to sick leave allowance, provided that:

- the resident doctor has not undertaken any other work outside the NHS during the break in service, apart from limited or incidental work during the period of the training appointment or voluntary service; and
- the employer considers that there has been no unreasonable delay between the training or voluntary service abroad ending and the commencement of the NHS post.

Limitation of allowance when insurance or other benefit is payable

Sickness allowance, when added to sickness benefit, severe disablement allowance, invalidity benefit, statutory sick pay, compensation payments or other social benefits receivable, may not exceed the resident doctor's normal salary for the period and the occupational sick leave allowance is restricted accordingly.

Notification of sickness

A resident doctor who is incapable of working because of illness should immediately notify their employer under the circumstances specified by the employer. If the sickness absence continues beyond the third calendar day, the doctor must submit a statement of the nature of the illness within the first seven calendar days of absence. Further statements must be submitted to cover any absence extending beyond the first seven calendar days. They should take the form of medical certificates completed by a doctor other than the sick doctor. Exceptionally, the employer may require statements to be submitted at more frequent intervals.

A resident doctor admitted to hospital must submit a doctor's statement on entry and on discharge in substitution for periodical statements. However, if the period of absence is less than seven calendar days, only a self-certificate is required.

'Fit notes' have now replaced sickness certificates. If you have any concerns about your sick leave or payment during this period, contact our team of advisers via [bma.org.uk/contactus](https://www.bma.org.uk/contactus)

Injury sustained on duty

It is important to note that a period of absence due to injury that is sustained by resident doctors in the actual discharge of their duties, and is not their own fault, is not recorded for the purpose of the scheme. It is essential that all such injuries are recorded at the first opportunity in the accident book or other mechanism for recording adverse incidents that may be in place.

Termination of employment

When a resident doctor is receiving the sick leave allowance at the time of expiry of their contract in a regular appointment, the allowance continues to be paid during the illness, ie after the contract would have been terminated, subject to the maximum entitlements set out in the 'Scale of allowances' section. This is an important provision of the sick pay arrangements, which is often overlooked by employers.

Accident due to sport or negligence

Sickness allowance is not paid in a case of accident due to active participation in sport as a profession or in a case in which contributory negligence is proved, unless the employer decides otherwise.

Recovering damages from a third party

A resident doctor who is absent as a result of an accident is not entitled to an allowance if damages are recoverable from a third party, but the employer may advance to the resident doctor a sum not exceeding the sickness allowance which would have been payable, subject to the resident doctor undertaking to refund any damages received.

Where a refund is made in full, the period of absence does not count against the sick leave entitlement. These provisions do not apply to compensation awarded by the Criminal Injuries Compensation Authority.

Medical examination

The employer may at any time require a resident doctor who is unable to perform their duties as a result of illness to submit to an examination by a doctor nominated by the employer.

Forfeiture of rights

If it is reported to the employer that a resident doctor has failed to observe the conditions of this scheme or has been guilty of conduct prejudicial to their recovery, and the employer is satisfied that there is substance in the report, the payment of the allowance can be suspended until the employer has made a decision. Before making a decision, the employer must advise the doctor of the terms of the report and provide an opportunity for the doctor to submit their observations and appear or be represented at a hearing.

SSP (statutory sick pay)

SSP is paid by the employer to employees. The sick pay paid by an employer will usually include both SSP and occupational sick pay entitlements. Where a doctor is entitled to occupational sick pay allowance equivalent to half pay and to SSP, the occupational sick pay allowance is increased by an amount equivalent to the amount of SSP due, except that the sum of the occupational sick pay allowance and SSP payable should not exceed the doctor's normal pay for the period.

Medical academic doctors

For trainees employed by higher education institutions the policies concerning sickness absence (including any qualifying period of service that may apply) are determined by the university employer who should be informed immediately according to local arrangements.

Further information

- Employment Relations Act 1999 www.legislation.gov.uk/ukpga/1999/26/contents
 - Maternity and Parental Leave Regulations 1999 amended by Maternity and parental leave (amendment) Regulations 2002 and 2001 www.opsi.gov.uk/si/si2006/draft/20064772.htm
 - Sections 7 to 13 of the GWC handbook: equal opportunities agreement
 - PCS(GC)2000/2 (Scot) [www.sehd.scot.nhs.uk/pcs/PCS\(GC\)2000\(2\).pdf](http://www.sehd.scot.nhs.uk/pcs/PCS(GC)2000(2).pdf)
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NHS pension scheme

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NHS pension scheme

Summary

This chapter provides an overview of the new NHSPS (NHS Pension Scheme) which was introduced on 1 April 2015. Most resident doctors will join this new scheme (unless they had membership of either the 1995 or 2008 sections of the NHS pension scheme previously and were within 13.5 years of the section's relevant normal pension age as at 1 April 2012) and all new employees will enter the new scheme automatically unless they opt-out.

On 1 April 2015 the new NHSPS (NHS Pension Scheme) was introduced for all new employees, and all current employees more than 13.5 years from normal pension age. All new employees will be automatically enrolled into the scheme on commencement of employment.

The scheme provides career average revalued earnings meaning that each year $1/54$ (equivalent to 1.85%) of the pensionable earnings accrue towards the pension. It is necessary to have in place a mechanism for revaluing previous years' earnings so that they do not lose value. Each year's accrual is revalued by the Consumer Prices Index plus 1.5%. The total of all the annual pension accrual amounts are added together at retirement to calculate the final pension.

Example

- If you earn £75,000 in pensionable income this year and the CPI rate is 3% your pension accrual for this year would be $1/54 \times £75,000 = £1,389$ and this accrual would be increased by the revaluation rate (CPI 3% + 1.5%) to £1,452.
- Every year the total of the previous years' pension accrual will be increased by the relevant rate for that year.
- Comprehensive information is available on the NHS Business Services Authority website, including how the 2015 pension scheme will affect you, how it is different to the existing scheme and information about opting-out. www.nhsbsa.nhs.uk/Pensions/4017.aspx

If you have not been able to find the answer you need on our web site, you can contact the BMA's pensions department if you need further help. Write to:

Pensions Department, BMA House, Tavistock Square, London, WC1H 9JP

Tel: 020 7383 6138 or 020 7383 6166

Fax: 020 7383 6484

Email: pensions@bma.org.uk

bma.org.uk/pensions

Travelling and other expenses

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Travelling and other expenses

References are made throughout this section to paragraphs in the GWC (General Whitley Council) conditions of service, which is still in use.

Summary

This chapter covers the expenses that resident doctors are entitled to claim in respect of travel on NHS business. It explains the NHS lease car system and the reimbursement rates for subsistence when doctors are away from home on NHS business.

Payment of mileage allowances

Resident doctors who are required to travel on NHS business are entitled to receive certain mileage allowances or may be offered a Crown/lease car. The circumstances under which residents may receive mileage allowances are set out in paragraphs 277-89 of the Terms and Conditions of service. The following is a brief summary of the provisions

Full time

Full-time resident doctors working in the NHS who are required by their employer to travel on official business receive mileage allowances for the following journeys:

- principal hospital to any destination on official business
- home to principal hospital, when the resident doctor is called out in an emergency
- home to principal hospital in certain other circumstances when there is a subsequent official journey
- home to any destination other than the principal hospital, on official business, subject to certain conditions.

The mileage payable for such journeys is usually subject to a maximum allowance. Paragraphs 284 and 285 of the terms and conditions of service set out the entitlement in detail.

LTFT (flexible trainees)

For LTFT resident doctors, the same provisions apply as to full-time resident doctors except for the home to principal hospital journey, when there is a subsequent official journey, as this is subject to a maximum. See paragraph 286 of the terms and conditions of service for further details.

In Scotland there is a national agreement (PCS(DD)2010/8) on the payment of relocation and excess travel expenses for doctors in the training grades [www.sehd.scot.nhs.uk/pcs/PCS2010\(DD\)08.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2010(DD)08.pdf)

In Northern Ireland the regional guide on relocation, removal and excess travel expenses for doctors in training has been agreed between the BMA and the DHSSPS and aims to provide clarification and improve consistency for employers on the interpretation of the terms and conditions of service.

This can be viewed at bma.org.uk/travelexpenses

Further information

- TCS paras 277-303
 - General Whitley Council Conditions of Service: Sections 23 & 24
 - AL(MD)2/2001 (Annex B in Pay Circular (M&D) 3/2006)
www.nhsemployers.org/~media/Employers/Publications/Pay%20circulars/pc_MandD_03-2006_aw.pdf
 - Scottish Executive, Rates of mileage allowance PCS(DD)2001/4 and PCS(DD) 2006/6 [www.sehd.scot.nhs.uk/pcs/PCS2006\(DD\)06.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2006(DD)06.pdf)
 - Northern Ireland, Mileage rates HSS(TC8)6/2008 and HSS(TC8)12/2001
 - BMA web guidance bma.org.uk/travelexpenses
-

Rates of mileage allowances

Resident doctors who use their own car on NHS business are entitled to allowances at the standard rate unless they are classified as regular users. Standard and regular user mileage rates vary according to engine capacity.

Regular users

Regular users are resident doctors who fulfil any of the following criteria:

- travel an average of more than 3,500 miles a year on NHS business; or
- travel an average of at least 1,250 miles a year; and
- necessarily use their cars an average of three days a week; or
- spend an average of at least 50 per cent of their time on such travel including the duties performed during the visits.

Regular users receive a lump sum that is paid in monthly instalments in addition to any mileage allowances due. Regular users may opt to be paid at the standard rates instead. The point at

which standard rates are more advantageous than regular user rates varies according to the resident doctor's tax position.

Insurance

Resident doctors who use their own car on NHS business should ensure that the car is insured for business use.

Public transport rate

The standard or regular user rates will not apply if a resident doctor uses a private vehicle in circumstances where travel by a public service (eg rail or bus) would be appropriate. For such journeys an allowance at public transport rate will be paid unless this is higher than the rate that would be payable under standard or regular user rates. It is important to note that public transport rate should only be paid where the use of public transport is not unreasonable, ie it is convenient and would not prolong the journey excessively. If it is not possible, or reasonable, to use public transport, standard or regular user rates should be paid.

In all other circumstances, the standard or regular user rates apply. Employers should use the following criteria in deciding whether the public transport rate should apply:

- the nature of the doctor's duties
- the length and complexity of journeys (including the number of changes and likely waiting times)
- the availability of public transport
- personal safety
- the time of day
- relative journey times (public transport compared with private vehicle)
- any other relevant factors, for example, equipment or luggage to be carried.

In particular, employers should take into account the variable times at which doctors start and finish work when public transport may not be a viable way of travelling. Additional guidance for resident doctors is available on the BMA website.

If a doctor needs to use private transport because public transport does not provide a reliable or reasonable way to get to or from work (or is in some other way inappropriate) or because they are travelling on an official journey, the standard or regular user mileage rates should apply. According to agreed guidance, as a general guide a

journey by public transport, which takes over one hour or which requires three or more changes, would be considered unreasonable and the standard or regular user mileage rates shall apply.

More detailed guidance on when the standard or regular use rates should be used is available in Pay Circular MD 3/2006 (www.nhsemployers.org/~media/Employers/Publications/Pay%20circulars/pc_MandD_03-2006_aw.pdf). For Scotland this is circular PCS(DD)2006/6 [www.sehd.scot.nhs.uk/pcs/PCS2006\(DD\)06.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2006(DD)06.pdf) and in Northern Ireland it is circular HSS TC8 12/2001.

Mileage paid at the public transport rate does not count towards the number of miles for which payment is made at higher rates under the standard and regular users mileage schemes. For example, a doctor who had to drive 3,000 miles and was paid at the appropriate standard rate for 2,000 miles and public transport rate for 1,000 miles would still be entitled to a further 1,500 miles at standard rate (ie the higher level paid up to 3,500 miles).

Further information

- TCS paras 290 & 298-9
 - Scottish Executive, Rates of mileage allowance PCS(DD)2001/4 and PCS(DD) 2006/6 [www.sehd.scot.nhs.uk/pcs/PCS2006\(DD\)06.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2006(DD)06.pdf)
 - AL(MD)2/2001 (Annex B in Pay Circular (M&D) 3/2006) www.nhsemployers.org/~media/Employers/Publications/Pay%20circulars/pc_MandD_03-2006_aw.pdf
 - Northern Ireland, Regional guidance on relocation, removal and excess travel expenses for doctors in training www.dhsspsni.gov.uk/hssgen_1_2010.pdf
-

Carriage of official passengers

A resident doctor carrying passengers who are employed by an NHS employer on NHS business, is entitled to receive a passenger allowance, at national rates.

Further information

- TCS para 300
-

Car out of use

Regular users unable to use their car because of illness or because their car has a mechanical defect will have the lump sum abated as follows:

- full payment will continue for the remainder of the month in which the car was originally not used, and for a further three months
- 50 per cent of the lump sum will be paid for the succeeding three months.

If the car is still out of use after this period, the lump sum payments will cease until the car is available again. During the time a car is off the road for repairs, the employer will pay reasonable expenses incurred in travelling for all classes of user.

Further information

- TCS para 296
-

Loans for car purchase

According to their terms and conditions of service, resident doctors are entitled to a loan at 2.5 per cent flat rate when they are first classed as 'regular users' provided they apply within three months of classification or appointment, whichever is the later. This entitlement does not normally apply to resident doctors offered a Crown car (see below).

The maximum amount of the loan cannot exceed the cost of the car less the net amount realised by the sale or part exchange of a vehicle used on NHS business within the preceding 12 months. The loan is repayable over a maximum of five years or the estimated life of the car, if shorter. If a resident doctor changes employer while repaying a loan the new employer will purchase the loan from the former employer.

Further information

- TCS para 302
-

Garage expenses, tolls and ferries

Garage and parking expenses, and charges for tolls and ferries, will be reimbursed to resident doctors using their cars on official business on the production of vouchers wherever possible. Overnight parking charges will only be reimbursed if the resident doctor is receiving night subsistence allowance for overnight absence or is receiving mileage expenses paid at public transport rates.

Further information

- TCS para 301
-

Pedal cycles

Official journeys undertaken by pedal cycle attract expenses at national rates.

Further information

- TCS para 303
-

Train fares

Resident doctors are expected to take the fullest possible advantage of any cheap fares available.

Further information

- GWC section 23
-

Air fares

Payment for travel by air may not exceed the cost of travel by appropriate alternative means of transport, together with an allowance equivalent to the amount of any saving in subsistence expenses consequent on travel by air, provided that where the employer decides that the saving in time is so substantial as to justify payment of the fare for travel by air, they may pay an amount not exceeding:

- the ordinary, or any available cheap fare for travel by regular air service; or
- where no such service is available or in case of urgency, the fare actually paid by the doctor.

Further information

– GWC section 23

The Crown/lease car scheme

A Crown or lease car is any vehicle owned or contract-hired by an employer. The Crown/lease car scheme was introduced for hospital doctors in 1990. Although the outline of the scheme has been agreed nationally and is applicable to all employers, it is operated locally and may vary considerably between employers.

Eligibility

Resident doctors are not automatically entitled to a Crown/lease car, but will be offered one if the employer considers it economic or in the interest of the service to do so.

Types of car

For resident doctors, a base vehicle of at least 1,100cc and no more than 1,800cc can be provided. A larger vehicle may be chosen but any excess costs compared with the use of the base vehicle are met by the individual resident doctor.

Petrol costs

Resident doctors who have been allocated Crown/lease cars are responsible for purchasing all petrol, whether for business or private mileage. Reimbursement for NHS business mileage should be claimed by submitting a signed claim form.

The rate per mile is determined according to the following formula:

$$\frac{\text{Cost of one gallon of LRP}}{\text{Base vehicle's mileage on urban cycle}}$$

The price of petrol is as notified from time to time by the Department of Health or devolved nation equivalent. The mileage on the urban cycle is as quoted by manufacturers from officially approved tests under the Passenger Car Fuel Consumption Order 1983.

Private charges

A Crown/lease car user will be required to reimburse the employer for the private use element of the car. This will take the form of a composite annual charge to cover payment for the road fund

licence, insurance for private use, a handling charge, VAT and a fixed amount per 1,000 miles of estimated private driving.

Implications of declining a Crown/lease car

A resident doctor may be asked to have a Crown/lease car by an employer as it is more economical for them to provide a car rather than reimburse travelling expenses at standard or regular user rate. If the request is declined the resident doctor will be reimbursed at a 'special rate' equivalent to the current 9,001 to 15,000 miles rate for over 2,000cc for regular and standard users, regardless of the vehicle's engine size. There is no entitlement to claim standard or regular user lump sum payments and allowances.

Taxation

As far as HM Revenue & Customs is concerned, private use of Crown/lease cars constitutes a tax benefit and their treatment is therefore the same as a company car given to any employee. Resident doctors interested in Crown/lease cars should be aware that the scheme will only be economically advantageous to some individuals, depending on variables such as private and business mileage, size of car, and the tax position. They are therefore advised to proceed with caution. BMA members should seek advice from our third party suppliers <https://www.bma.org.uk/pay-and-contracts/your-finances/your-finances-and-protection/medical-accountancy-and-tax-advice> and/or their accountant.

Further information

- TCS paras 304-308
 - AL(MD)2/90
 - Scottish NHS Circular 1990(PCS)27 www.msg.scot.nhs.uk/wp-content/uploads/Circulars/PCS's/PCS%20Publications%20DD/pcs%201990%2027.pdf
 - Northern Ireland HSS(TCS8)9/90 (NI)
-

Subsistence allowances

Subsistence allowances are payable in addition to travelling and other expenses when resident doctors are required to be away from their home. For example, they can claim in relation to periods of approved study leave, interview expenses, or in connection with removal expenses during a search for suitable permanent

accommodation in a new area, subject to the terms of the employer's removal expenses policy.

The following allowances are currently payable.

Night subsistence – commercial accommodation

When a resident doctor stays overnight in a hotel or other commercial accommodation, the overnight costs will be reimbursed as follows:

- the actual receipted cost of bed and breakfast up to a normal maximum limit of £55; plus
- a meal allowance of £20 to cover the cost of main evening meal and one other daytime meal.

In exceptional circumstances where the maximum limit is exceeded (eg the choice of hotel was not within the claimant's control or cheaper hotels were fully booked), additional assistance may be granted at the discretion of the employer.

Night subsistence – non-commercial accommodation

Where a resident doctor stays for short overnight periods with friends and relatives or in caravan accommodation, a flat rate of £25 is payable. This includes an allowance for meals. No receipts are required.

Resident doctors staying in accommodation provided by the employer or host organisation are entitled to an allowance to cover meals which are not provided free of charge up to £20.

Where accommodation and meals are provided without charge, an incidental expenses allowance of £4.20 is payable. All payments of this allowance are subject to the deduction of income tax and NI through the payroll system.

Travelling overnight

The cost of a sleeping berth (rail or boat) and meals, excluding alcoholic drinks, will be reimbursed subject to the production of receipts.

Short-term temporary absence travel costs

Travel costs between the hotel and temporary place of work are reimbursed on an actual costs basis.

Day meal allowances

A meal allowance is payable when a resident doctor is absent from home and more than five miles from headquarters, by the shortest practical route, on the business of the employer. The rates are as follows:

Lunch allowance – £5

(more than five hours away from base including the lunchtime between 12 noon and 2pm)

Evening meal allowance – £15

(more than 10 hours away from base, returning after 7pm)

The above allowances are not paid where meals are provided free at the temporary place of work.

A day meal allowance is only paid when a resident doctor spends more on a meal/meals than would have been spent at the resident doctor's headquarters. A resident doctor is required to certify accordingly on each occasion for which a day meal allowance is claimed, but a receipt is not required.

Resident doctors may qualify for both lunch and evening meal allowance in some circumstances. There will be occasions where, due to the time of departure, it will be necessary to take a meal but the conditions relating to the time absent from the base are not met. This, and any other exception to the rules, may be met at the discretion of the employer.

Late night duties expenses

A resident doctor may also receive in addition to a day meal allowance, an evening meal allowance of £3.25. This is paid at the discretion of the employer and is subject to income tax and NI contributions.

Receipts

The subsistence rates above are payable in full when resident doctors are away from home on official business. There is no requirement under the GWC agreement that staff should produce supporting vouchers/receipts, except in the case of claims for very long absence allowance, overnight bed and breakfast costs, train meal allowances or for abnormally high expenses. However, local

policies (which do exist) may require receipts, and the position should be checked before claiming.

Further information

- TCS para 311
 - GWC section 22
-

Telephone expenses**Resident medical staff**

Under HSC 2000/036 'Living and working conditions for hospital doctors in training' (HDL(2001)50 in Scotland), resident resident doctors should be provided with a telephone connected, using a standard BT or cable socket, to the internal hospital telephone system and for there to be access to the facility for making external calls at no higher than relevant BT rates. It is BMA policy that resident doctors should not be charged more than the actual charge of the call made by the telephone company.

Official business calls

Resident doctors may claim the cost incurred of outgoing calls made on official business.

Telephone installation and rental costs

It is sometimes a contractual requirement for SpRs and StRs to possess a telephone. Employers should pay for the cost of installation and rental of telephones where they are satisfied that the following conditions apply:

- it is essential for the efficiency of the service that the resident doctor should be on-call outside normal working hours; and
 - the telephone is the only practicable method of communication with the resident doctor; and
 - the possession of a telephone is a contractual requirement.
- However, contract holders are also entitled to reimbursement of the cost of calls by the employer.

The payment of installation and rental costs is usually taxable.

Further information

- HSC 2000/036 http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4003955
 - Scotland HDL(2001)50, SHM4/1971 and 1979(PCS)32
 - HM(58)68
 - Wales WHC(PC)(79)3
 - Northern Ireland HSS(TC8)11/79
-

Interview expenses

Where an employer invites a resident doctor to appear before a selection board or invites a shortlisted resident doctor to attend in connection with an application for appointment, reimbursement of eligible expenses is made by the prospective employer. (For specialty training interviews in Scotland, candidates offered an interview who are based in Scotland are advised to claim from their current employer, ie their local health board. Trainees from outside Scotland are advised to claim from the lead board dealing with recruitment for the specific specialty.)

The applicant is entitled to travelling expenses and subsistence allowances at the appropriate rates. A candidate will not be reimbursed for more than two attendances, except that a candidate for a consultant appointment may be reimbursed up to three attendances. If an employer invites such a candidate to attend prior to shortlisting, it may reimburse the expenses provided that the candidate is subsequently shortlisted.

A resident doctor who is requested to appear before a selection board while on holiday is reimbursed for:

- travelling expenses from the holiday address, but limited to travelling expenses from the port of entry if the resident doctor is abroad, and provided they return to the holiday address after the interview. Travel from Northern Ireland, the Isle of Man and the Channel Islands is not regarded as travel from abroad, and therefore travelling expenses should be met in full
- subsistence allowances at the appropriate rate, unless the resident doctor is able to stay at home and it is reasonable to expect them to do so.

Expenses may be reimbursed for pre-interview or pre-application visits for specialty registrar appointments. The prior agreement of the prospective employer should be obtained.

Reimbursement is not made to a resident doctor who refuses the offer of an appointment as advertised on grounds which the employer considers inadequate.

Further information

- TCS para 313
 - AL(MD)4/98 http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Advancedletters/DH_4080524
 - PCS(DD)1999/2
 - Northern Ireland TC8 5/99
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Postage

Any expenditure incurred by a resident doctor in postage in the service of an employer is reimbursed by the employer.

Further information

- TCS para 312
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Removal
expenses

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Removal expenses

Summary

This chapter covers the expenses that resident doctors are entitled to claim when moving to satisfy training needs, including the reimbursement of removal expenses, legal costs and other services.

The scheme for reimbursement of removal expenses gives employers discretion on the scope and level of removal expenses that they may reimburse. However, training grade doctors remain entitled to reimbursement of their removal or excess daily travelling expenses, and employers have been asked to take particular account of the circumstances of those who have to move frequently to satisfy their training needs, so that they are not disadvantaged by these moves.

Before accepting an appointment, doctors who would have to move to take up that appointment should contact the new employer as early as possible to check their eligibility for removal expenses. There is no national policy for the provision of removal expenses for clinical academics by university employers. This is very important because of the discretion which has been given to employers to determine eligibility.

It should be made clear that employers must reimburse removal expenses for resident doctors who are required to relocate in the interests of the service or to satisfy their training requirements.

As much information as possible should be obtained from the human resources department before accepting a post. Negotiation of removal or travel expenses should take place before the post is accepted, and confirmation of any agreement should be obtained in writing.

Resident doctors may find that their employer has negotiated a removal expenses agreement covering all staff. The BMA has issued guidance to its LNCs on negotiating such a package. Nevertheless, individual doctors may now have to play a greater role in negotiating their own expenses. In addition, some regions have established removal expenses policies covering all employers in the region and this will often include setting a limit on claims, usually of about £8,000 (above which any relocation payments become taxable).

Further information

- GWC handbook section 26
 - AL(GC)1/93
 - AI(MD)7/93 – Removal expenses: hospital medical and dental staff and doctors in community medicine and the community health service
 - Scotland PCS(GC)93/1 and PCS(DD)2010/8
 - Northern Ireland HSS(TC1)7/93, HSS(TC8) 6/95 and guide for relocation HSS GEN 1/2010
 - GWC handbook, section 26 para 3
 - Wales deanery walesdeanery.org
-

Rotational appointments

Doctors who have to move during a rotational training appointment can choose to travel the greater distance between their home and their place of work on a daily basis instead of moving house. The mileage that may be paid under these circumstances is the difference between the mileage from home to their designated base place of work and the mileage from home to the new place of work, as set out in paragraph 315 of the terms and conditions of service. In most cases the base place of work is where the majority of time and/or work is spent. (In Scotland, there are five defined base hospitals for the 'purpose of payment of excess travel expenses'.)

Further information

- Terms and conditions of service, para 315
 - AL(MD)2/01
 - PCS(DD)2010/8 (Scot)
[www.sehd.scot.nhs.uk/pcs/PCS2010\(DD\)08.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2010(DD)08.pdf)
-

LTFT training

LTFT trainees should negotiate reimbursement of removal expenses directly with their new employer. The terms and conditions of service do not preclude full reimbursement to those moving into LTFT training, however if members experience difficulties with receiving reimbursement or would like advice on how best to approach their employers they should contact our team of advisers via bma.org.uk/contactus

GP trainees

Doctors who are on a GP training programme and who move from a hospital placement to a GP practice placement, or who move from one GP practice placement to another, and out of necessity change their accommodation are entitled to removal expenses.

Honorary contract holders

A doctor moving from a post with a university, the MRC (Medical Research Council) or the Wellcome Trust where they held an honorary NHS contract will probably be eligible to receive removal expenses on return to the NHS.

Doctors moving from the NHS to MRC or university appointments will receive whatever removal expenses are payable by the MRC or individual university. Universities do not always pay removal expenses though it may be available if discussed in advance of agreeing a contract.

Please read the section on medical academics in this handbook or refer to the *Medical academic handbook* for further information.

Responsibility for payment

The doctor's new employer is responsible for the payment of expenses.

Agreement to remain in service

As a condition of receiving removal expenses, employers may require some groups of doctors to sign an undertaking that they will not leave the service of that employer within two years unless the circumstances justify the release of the doctor from this undertaking. If this is broken, the doctor may be required to refund all or part of the expenses.

In Scotland, any relocation expenses paid to specialty registrars are not recoverable, as long as the StR remains working for NHS Scotland for two years. If the StR leaves the employment of NHS Scotland within two years of receiving their relocation package, they are required to repay a pro rata amount as per section 26 of the GWC.

Relocation expenses for FHOs are in line with the locally agreed relocation policy.

Doctors in training should be wary of signing a contract containing an agreement to remain in service as it is often the case that they will leave the employer's service within two years for training reasons. Our team of advisers can advise on the best course of action if this occurs. bma.org.uk/contactus

Further information

- GWC handbook, section 26, paras 5 and 9
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Level of expenses payable

Under the GWC agreement employers should, prior to the post being accepted and in agreement with the employee, determine the scope and level of financial assistance to be provided. The provision of removal expenses will form part of the contract of employment. Employers have been asked to ensure equity between different categories of staff, and should take into account both their own interests and the needs of prospective employees. The employer must also 'clearly indicate the aspects of removal costs that will be reimbursed, and, where applicable, the upper limit of payment in all usual circumstances'.

This implies that there may be considerable variation in expenses offered according to factors such as area, ease of recruitment in a particular specialty etc. Employers must, however, also take the following into account when considering the level of expenses:

- all the individual's circumstances
- the need to re-house dependants
- comparability of old and new accommodation.

Doctors will need to be aware that expenses offered may vary, although expenses should be based on costs actually incurred. There should be a clearly set out appeals procedure to cover cases of disagreement.

Legal and other services

Employers are given discretion to establish, in negotiation with the employee, the procedure to be followed and costs to be reimbursed where an employer has entered into an agreement with solicitors

or other agencies to provide house purchase, conveyancing or removal services at preferential cost.

The BMA is opposed to the concept of employers imposing their choice of legal or other services on an employee. Doctors who wish to choose their own solicitor etc should establish at an early stage whether this is acceptable, and should note that if they use their own solicitor, the employer may impose an upper limit on reimbursable expenses based on their own agency's charges.

Making a claim

Step 1: the agreement

- Contact the human resources department of the prospective employer and find out in detail how they plan to calculate and pay removal expenses.
- Contact our team of advisers via bma.org.uk/contactus to check that the offer is in line with any local agreement on removal expenses, and that it is reasonable.
- Use the list as a guide to the possible costs, which should be covered in the offer.
- Do not accept an appointment until agreement is reached on the range and level of expenses.
- Get the employer's agreement in writing and check whether there is a time limit on submitting a claim.
- Keep all receipts, and check whether those are needed for all expenses or whether miscellaneous expenses can be claimed without them.

Step 2: what to claim

The GWC scheme states that any reasonable costs incurred in relocation may be met, including those incurred in:

- the search for accommodation in the new area
- the purchase and sale of property (this includes legal fees and stamp duty)
- removal of furniture and effects
- continuing commitments in the old area
- general/miscellaneous removal costs
- additional housing costs in the new area
- other expenses, at the employer's discretion.

The following are offered as a non-exhaustive example only and are neither inclusive or exclusive.

Expenses during search for accommodation

- Preliminary visits to new area (paid leave and expenses, including immediate family).
- Subsistence allowance for a maximum of four nights away while seeking accommodation.
- Return travel expenses (including immediate family).
- Travel expenses for weekly visits home or by the immediate family to the doctor until new accommodation has been found (for a maximum of 12 months).
- Allowance for retention of accommodation in new area while absent (for a maximum of 12 months).

Expenses of house purchase and sale

- Advance of salary for house purchase (ensure repayment terms are clear).
- Legal and other expenses (eg stamp duty, legal fees, surveys, wiring/drains test).
- House sale (eg solicitors' fees, agents' fees, costs relating to a purchase which falls through).

Expenses of moving house

- Journey from old to new home, with immediate family.
- One return visit to superintend removal.
- Storage and/or removal of furniture/effects (three quotes must be sought).
- Tenancy agreements.
- Miscellaneous (eg plumbing, telephones, replacement of school uniform, TV aerial, etc).

Continuing expenses in old area

The employer may reimburse any reasonable continuing commitments in the old area, eg:

- child's lodging costs (where they remain behind)
- rent and rates payable on the old property concurrently with the new one.

Additional expenditure in new area

The employer may make allowances towards additional housing costs where the cost of accommodation is higher than in the old area, eg:

- increased expenditure in new area compared with similar expenditure in old area for:

- rent/rates
- property insurance
- other (covering rent or imputed equivalent, council tax, water rates, etc).

Step 3: what to avoid

- Loans, offered as an alternative to removal expenses.
- Undertakings to repay if moving within a fixed period.
- Lump sum settlements: tax rules mean that tax may be payable.
- Overall ceilings on expenses: the BMA is opposed to these.

Tax

Removal expenses can be paid tax-free up to a 'qualifying limit', which is revised from time to time. Currently, the limit stands at £8,000. Further information can be obtained from our website: bma.org.uk/practical-support-at-work/pay-fees-allowances/removal-expenses/tax-on-removal-expenses. Your local tax office will also be able to help. Also be aware that to get tax relief your expenses must be incurred, or the benefits provided, before the end of the tax year following the one in which you start your new job (a tax year runs from 6 April one year to 5 April the next).

Further information

- Finance Act, 1993, section 76, schedule 3
 - Wales deanery walesdeanery.org
 - HMRC guidance www.hmrc.gov.uk/guidance/relocation.htm
 - BMA guidance bma.org.uk/removalexpenses
 - Northern Ireland guide for relocation, HSS GEN 1/2010
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Accommodation and catering

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Summary

This chapter covers entitlements to accommodation, overnight accommodation when on-call and working full-shift rota patterns, accommodation standards and catering provisions.

Accommodation and catering

If a doctor's duties require them to be resident then the employer is required to provide accommodation. In addition, if a doctor, for good reason, cannot obtain suitable accommodation and whose recruitment and retention would otherwise prove difficult the employer may provide accommodation. Both single and married accommodation may be provided in all cases, although the provision of married accommodation will be subject to its availability.

There is no longer a statutory requirement in the UK for pre-registration doctors (first year foundation doctors [F1s]) to be resident, which in turn means that hospital accommodation no longer needs to be provided without charge to F1s in England, Scotland, Northern Ireland and Wales. However, in Wales, accommodation continues to be provided free of charge to F1s. Further details are available on the BMA website.

Resident doctors

The lodging charges for voluntarily resident resident doctors are a matter for negotiation by each employer at the LNC.

Lodging charges for existing accommodation should be increased at the same time, and by the same percentage, as increases in resident doctors' pay. Lodging charges may not be increased without agreement following local negotiation. Further increases must be by reasonable amounts in order to move towards charges which reflect the standard of accommodation provided and the local market value.

Employers are advised to seek a professional assessment of the rent their accommodation would be likely to command in the open market. Employers should also be aware of rent levels generally for comparable accommodation in their area and should consider recruitment and retention, as well as cost issues.

Lodging charges for new accommodation will be determined by local negotiation and agreement to reflect the standard of accommodation provided and notional market value.

Further information

- Terms and conditions of service, paras 173-4
 - AL(MD)4/95 Lodging charges for voluntarily resident practitioners
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Advancedletters/DH_4004008
 - Northern Ireland HSS(TC8)15/95
 - Scotland PCS(DD)1995/5
-

Overnight accommodation when on-call

No charge should be made for on-call accommodation for resident doctors who are required to stay overnight in the hospital as a condition of employment. This is detailed in paragraph 173a of the terms and conditions of service.

If a doctor is working a full-shift pattern but is not required by condition of appointment to be statutorily or compulsory resident at the hospital then they are not eligible for free accommodation.

If a doctor is required to stay overnight as part of an on-call or partial-shift pattern one night in seven or more then they are required to pay a proportion of accommodation charges if they are not eligible for free accommodation. This is detailed in paragraph 175b of the terms and conditions of service. On-call/rest rooms should be available for all resident doctors and should be free of charge. If your employer wants to impose a charge contact our team of advisers for assistance via bma.org.uk/contactus

Accommodation for doctors on full shifts

Even with the New Deal and EWTD provisions in place, a resident doctor could still be working 13 consecutive days consisting of 14-hour shifts. In addition to this, travel time to and from work following a 14-hour shift results in severely depleted opportunity to sleep, potentially exacerbated by lengthy journeys for doctors in rotations that cover large geographical areas. The provision of accommodation during or outside duty periods would allow doctors to take anchor sleeps of 10 to 40 minutes, which are well researched as being effective in reducing fatigue. This would hopefully address the fact that resident doctors who are seriously fatigued while on duty increase the risk of making clinical errors, turning routine

procedures into high-risk procedures, which is clearly unacceptable for the patient.

A substantial body of research has been carried out into the negative effects of working long hours, for example, the RDC is aware of several cases where resident doctors have had road traffic accidents on their way home from long shift periods. Employers need

to extend their concern for their employees beyond the confines of the hospital, particularly as some full-shift rotas have late finish times, eg midnight or later.

A judgement in the ECJ (European Court of Justice), known as the Jaeger judgement, ruled on the way in which on-call work should be regarded. It notes the specific case of removal of accommodation during duty periods and permit of sleep while on duty on the hospital site. The RDC recognises that accommodation facilities are frequently unfavourable to restful sleep and also that with cross-cover arrangements within a full-shift arrangement there is less likelihood of sleep being possible while on duty.

This opinion, as well as confirming the position in SiMAP, goes further by suggesting that a bed provided to a doctor on duty to enable him to rest from time to time contributes to protecting his health and to ensuring that he is able to attend properly to patients. More details on the Jaeger judgement can be found in the EWTD section of this handbook.

Further information

- Suggested resources on anchor sleeps:
 - Sallinen M, Harma M, Akerstedt T et al (1998) Promoting alertness with a short nap during a night shift. *J Sleep Res* 7: 240-7.
 - Purnell MT, Feyer AM, Herbison GP (2002) The impact of a nap opportunity during the night shift on the performance and alertness of 12-h shift workers. *J Sleep Res* 11: 219-27.
 - BMA joint position statement on on-call rooms
www.asit.org/assets/documents/JDC_AoMRC_oucallrooms.pdf
 - SRDC paper: *Shift-work, rest and sleep: minimising the risks*
bma.org.uk/sc/employmentandcontracts/working_arrangements/work_patterns/shiftwork.jsp
-

Accommodation between duty periods

In circumstances where intervals between duty periods make it unreasonable for the resident doctor to travel to their home or usual residence, for example between shift duties hospital employers do have a duty of care to ensure the safety of their employees and as best practice should offer to provide free accommodation.

This decision is at their discretion. For those doctors who are too tired to travel home following a late handover in the morning and who feel too tired to drive, an adequate rest facility should be made available in order for the doctor to recuperate before driving home.

Many hospital employers only provide a rest room with a chair or a recliner. This should not be considered adequate when there is a requirement for proper rest.

Abatement of voluntary lodging charges

Abatements are given to compensate a doctor for being away from their accommodation for work purposes. Resident doctors who are required to stay overnight in hospital as part of an on-call rota or partial-shift system one night in seven or more often, but who are not contractually eligible for free accommodation, shall pay the following proportion of the lodging charge.

Required to stay overnight	Proportion
One night in three	0%
One night in four	35%
One night in five	55%
One night in six or seven	75%

Due to the increasing tendency for employers to hand over responsibility for their rented accommodation to housing associations, resident doctors may find difficulty in claiming these abatements. If a housing association just manages the accommodation the abatements should still apply. If a separate body owns the accommodation the position is less clear. In such cases, advice should be sought from our team of advisers via bma.org.uk/contactus

Often in such circumstances, resident doctor accommodation is situated off site requiring the doctor to travel to the hospital. In order that a doctor is able to meet their clinical commitments on time consideration should be given that adequate parking is available at the accommodation. If this is not possible then a suitable transport system should be set in place by the employer.

Further information

- Terms and conditions of service, para 175
 - HC(91)9
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Inadequate standard of accommodation

Charges made for accommodation should reflect the standard and amenities provided. Should standards fall below the minimum stated in Annex A of HSC 2000/036 (http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4003955); (HDL(2001)50 in Scotland (www.sehd.scot.nhs.uk/mels/HDL2001_50.pdf); HSS(TC8)1/2002 (NI) in Northern Ireland (www.dhsspsni.gov.uk/hsstc8_1_2002.pdf).

Employers must provide the accommodation free of charge until improvements have been completed. In Wales the 'Standards for hospital residential accommodation and associated support facilities' can be found here: <http://wales.gov.uk/topics/health/publications/health/reports/standards/?lang=en>

Where applicable, should the accommodation fall below the HIMOR standards (Annex A) employers should provide alternative accommodation until the HIMOR notice has been lifted or the residents contract comes to an end. Should an employer provide sub-standard accommodation the following penalties will apply:

Standards falling below the minimum safety standards – accommodation must be closed immediately and alternative arrangements made by the employer.

Standards falling below the minimum stipulated in HSC 2000/036, or HDL(2001)50 in Scotland, or the current standards in Wales, or HSS(TC8)1/2002 (NI) in Northern Ireland – accommodation must be free until improvements are completed (within an agreed timescale) and training posts should be advertised accordingly.

Standards still falling below the minimum stipulated in HSC 2000/036 or HDL(2001)50 in Scotland, or HSS(TC8)1/2002 (NI) in Northern Ireland after an agreed date for improvement – no training posts should be advertised until the employer has reached minimum standards. Employers would also be required to find alternative accommodation for any trainees in post, and to provide transport to and from hospital if necessary.

Self-contained accommodation

The provision of self-contained and married accommodation varies from hospital to hospital. All accommodation must meet the minimum standards set out in HSC 2000/036 or HDL(2001)50 in Scotland or the current standards in Wales. There is no requirement for employers to provide this accommodation and where such accommodation is provided the quality tends to vary.

Resident doctors requiring married accommodation should check that such accommodation is available from the employer before taking up the post.

Further information

- HSC 2000/036 Living and working conditions for hospital doctors in training http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4003955
 - HDL(2001)50 in Scotland
 - Northern Ireland HSS (TC8) 1/2010
 - The current 'Standards for hospital residential accommodation and associated support facilities' in Wales can be found at <http://wales.gov.uk/topics/health/publications/health/reports/standards/?lang=en>
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Rent rebates

Married resident doctors who occupy NHS accommodation on a rental basis because they are required to be resident are eligible to receive abatements of up to 25 per cent of assessed rent and up to 50 per cent if both husband and wife are compulsorily resident. This includes a further abatement of 10 per cent over and above what is offered to other staff in recognition of the fact that no charge is made for lodging in the case of a doctor occupying single hospital accommodation where residence is a condition of appointment. In exceptional cases, for example, where a doctor is required to occupy a house far in excess of their normal needs or at a rent out of all proportion to what they might normally pay, an abatement of over 25 per cent may be permitted.

The rent of a house or flat occupied by a doctor who is appointed for one year or less should not be revised during the term of the appointment and any revision of the rent following a review should be deferred until the end of the tenure in such cases.

Tenancy agreements

The NHSE (NHS Executive) issued model tenancy and licence agreements, to be used according to circumstances. Essentially, these are classified as:

- an assured tenancy agreement
- an assured shorthold tenancy agreement
- a licence agreement.

A licence agreement offers no security of tenure and merely licenses the occupation of the premises. An assured tenancy is the most common form of agreement between private landlords and their tenants. It cannot be used for properties that are not let as separate dwellings or are the individual's only or main home. Resident doctors are therefore most likely to be offered assured shorthold tenancies.

An assured shorthold tenancy offers the landlord a guaranteed right to repossess the property at the end of the agreed period of the tenancy. The first assured shorthold tenancy must not be for less than six months and at least two months' notice is required to bring it to an end. A model fixed-term tenancy agreement, which was agreed with the NHSE is available from our team of advisers via bma.org.uk/contactus

Rents under this type of tenancy should not be increased during the term of the tenancy, though they are exclusive of service charges, which may be added on (see below).

Service charges

Employers usually arrange for the installation of a meter for each unit of accommodation to assess the consumption of gas and electricity. The charge is laid down by the gas or electricity company and paid directly by the individual. In some cases, where meters are not installed, the employer may include these charges in the accommodation charge. Employers are also required to add to the assessed rent a sum equivalent to the cost of any services such as central heating, which they provide, though this must reflect a reasonable level of consumption and take account of the difficulty usually encountered by individual residents in controlling their own heating.

Employers may also add a sum to cover the cost of 'furniture and fittings' based on the gross value of the furniture when new.

Standards of accommodation

HSC 2000/036 'Living and working conditions for hospital doctors in training' or HDL(2001)50 in Scotland or current standards in Wales sets out the minimum standards of accommodation and catering for resident doctors. These agreed minimum standards are the result of discussions between resident doctors' representatives, regional New Deal task force officers, representatives from postgraduate deaneries, NHS managers, NHS Estates staff and other interested parties. The agreement stipulates the following minimum standards.

The agreed minimum standards in Wales can be found at wales.gov.uk/topics/health/publications/health/reports/standards/?lang=en and may differ from those listed below.

On-call rooms

Employers need to have sufficient numbers of rooms for all on-call or partial-shift resident doctors, whether this be during all or part of any particular night on duty. In addition to this all on-call rooms should be of the same standard as residential accommodation.

The on-call rooms should be a separate unit away from clinical areas, though at a maximum of between five and 10 minutes walking distance from the relevant wards. The rooms must not be built next to power plants or goods delivery areas, or other areas that could disturb occupants' rest.

Access to and from the on-call rooms, doctors' mess and clinical areas should be safe and without risk to health or welfare, for example, well lit.

Bedrooms

Each bedroom (one per occupant) should have the following:

- adequate light and sound proofing, ventilation, temperature adjustment, and security; suitable floor covering; lined curtains; bed (3ft) (double [4ft 6in minimum] for married accommodation); weekly linen change and twice weekly towel change (for on-call rooms, change of bedlinen and towels between occupants); desk and chair; wardrobe, drawers and bookcase/shelves; easy chair; reading light by bed and desk; room cleaned three times a week; smoke alarm in the room; a standard BT or cable socket to the internal hospital telephone system; access to the facility for making external calls at no higher than relevant BT rates; a wash basin with hot and cold running water.

Bathrooms

Each bathroom (one between two occupants, previously one between three) should have the following:

- shower which is fed by both hot and cold water and fitted with a device such as a thermostatic mixer valve to prevent users being scalded; bath; toilet.

Kitchens

Each kitchen (one between four occupants) should have the following:

- cooker (four rings and oven); microwave; fridge-freezer; utensils for cooking and eating; kettle; toaster; steam iron and ironing board; smoke alarm in the kitchen.

Dining areas

Dining area (one between four occupants) should have the following:

- table; at least one chair per occupant.

Living rooms

Living room (one between four occupants):

- sufficient seating for all occupants using sofas and comfortable chairs; and a coffee table.

Star rating system

Only once all the minimum living and working conditions stated above have been achieved, may employing authorities improve the facilities offered to resident doctors by including extra facilities. The employer will then receive a star rating from one to three depending on the number of additional facilities they provide.

Incorporating five of the following items	=	one star
Incorporating 10 of the following items	=	two star
Incorporating 15 of the following items	=	three star

This will encourage employers, for just a small extra investment, to attract resident doctors to their hospital by providing accommodation and other facilities of a high standard.

Bedroom

Double bed
En suite shower
Daily towel and linen change
Duvet (minimum 12 tog)
Radio/alarm clock
Tea/coffee making facilities
Facilities for IT/internet access
TV aerial connection

Kitchen

Filter coffee machine
Automatic washing machine
Tumble dryer
Dishwasher

Living room

TV and video recorder

IT/internet access

Miscellaneous

Indoor and locked communal cycle store

Car parking on site

Double glazing

Security – internal voice communication with front door and camera link with main door

Catering

Resident doctors on duty must be able to get good quality hot and cold food at any time. If the canteen is closed, this should be through a supply of microwave meals, cold cabinet or a similar arrangement.

Supplies should be sufficient for all staff on duty, and readily accessible to doctors in training, usually within the resident doctors' mess. Supplies should be regularly restocked, with swipe cards or change machines provided where necessary.

Bread, cereals and drinks should be available at all times.

In small hospitals (where there are fewer than 10 resident doctors on-call at any one time) canteen opening hours can be reduced from the minimum standard set out below. However, the minimum standard (availability of good quality hot and cold food round the clock) must be observed.

Where catering facilities exist, they must be open 365 days a year.

Meals provided must be adequate, varied, attractively and efficiently served and freshly prepared.

Canteen must be open and serving hot food for extended meal times for breakfast, lunch and dinner, wherever possible with a minimum late opening until 11pm and a further two-hour period after 11pm and before 7am.

Resident doctors are no longer required to remain on site and therefore many employers do not provide extended meal times after 11pm. If the canteen is closed then it is important that food is available in the mess through a supply of microwaveable meals.

Canteen must always provide healthy eating options and a vegetarian option, and should provide for a range of cultural and dietary requirements.

Serving and dining areas must be situated away from facilities provided for patients, relatives and other non-employees.

Monitoring and complaints

There should be a designated named employer officer to whom resident doctors can address complaints and concerns about facilities.

An independent facilities inspection officer will inspect hospital facilities on a regular basis, and work with and ensure that employers improve any sub-standard facilities.

Recreational and other facilities

There should be a doctors' mess easily accessible from wards and departments.

In large hospitals this may require more than one mess. In small hospitals a joint mess for all clinical staff may be acceptable.

Resident or on-call resident doctors should have access to a parking space near their accommodation where on-site car parking is available. Where this is not available, employers should attempt to ensure that alternative secure parking arrangements are in place.

- Secure, communal cycle store.
- Laundry with an adequate number of washing machines and dryers (reasonably priced and well maintained).
- Exercise/sporting facilities for all staff – where this is not possible, employers should make arrangements with local sports centres and swimming pools and should inform residents of these facilities.

Guidance on hospital accommodation and catering

The RDC has produced guidance on hospital accommodation and catering based on HSC 2000/036 'Living and working conditions for hospital doctors in training' or (HDL(2001)50) in Scotland or current standards in Wales. A copy of the guidance is available via the BMA website. In addition a toolkit is available on the BMA website for doctors in England to check the standard of their hospital accommodation.

Further information

- BMA guidance and standards for living and working conditions for hospital doctors in training: [bma.org.uk/practical-support-at-work/contracts/juniors-contracts/accommodation/accommodation-full](https://www.bma.org.uk/practical-support-at-work/contracts/juniors-contracts/accommodation/accommodation-full)
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OOP (Out of
Programme)
experiences

22

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Summary

This chapter explains the different types of OOP options, application details and how to return to training.

OOP (Out of Programme) experiences

The purpose of time spent OOP is to allow trainees to take up opportunities that their training programme would otherwise prevent. Depending on the activity, time spent OOP may or may not contribute towards the CCT (Completion of Training Certificate) as the nature of the activity will determine for how long a training programme should be extended.

Different types of OOP

- OOPT** Out of Programme Experience for Training, which has approval from the GMC and will contribute towards obtaining your CCT.
- OOPE** Out of Programme Experience for Clinical Experience (which has not received approval from GMC for contribution towards a trainees CCT).
- OOPR** Out of Programme Experience for Research (including a registerable higher degree) can be up to three years.
- OOPC** Out of Programme Experience for a career break (eg to work in industry, or for ill-health reasons).

OOP and CCT

An OOP will only count towards CCT if it is undertaken as an OOPT. In this instance, approval will be provided in advance from the GMC.

Application details

Application processes vary depending on the deanery/LETB and therefore it is recommended you check the specific deanery/LETB website for guidance specific to the region.

If OOPT is being undertaken, the deanery/LETB will apply for approval to the GMC. The GMC is the only body which can give, amend or withdraw training approval for any OOP intended to lead to the award of CCT.

Full details of the approval process are on the GMC website at www.gmc-uk.org

The GMC will not accept applications for OOP directly from the trainees or the respective colleges.

Application timeframes

The deanery/LETB will normally want trainees to have been in their current training programme for at least a year before they can apply for time OOP. Deferring the start of a training programme is slightly different, and deans will not normally agree to deferment except on statutory grounds like maternity, or for time to complete a higher degree.

Duration of OOP

This will depend on the nature of the project/task being undertaken. There will need to be a declaration of the return date in the application to the deanery/LETB. The Gold Guide states that an OOP will normally be up to one year, but exceptionally can be up to two years. However, for longer periods and with OOPR, discussions should take place with the deanery/LETB at the time of making an application. The deanery/LETB will then be able to confirm if the trainee will retain their NTN number.

Returning to training

It is important to adhere to guidelines set by the deanery/LETB to ensure that the training post is still available once the OOP has finished, in particular to the specifications imposed by your deanery and GMC with regards to the nature of your work undertaken OOP and your obligations to keep the deanery/LETB up to date (including for ARCP/RITA purposes) during the time OOP. Ensure adequate notice of the intention to return to work and provide at least six months' notice of the intended return to work.

Application refusal

If the application for time OOP is refused or the GMC will not approve time OOP for contribution towards CCT the following course of action is recommended. Write to the deanery/LETB to request written confirmation of the reasons the application for OOP was refused and written confirmation of the amendments to the application that would satisfy their criteria for an OOP request.

Upon receipt of the letter from your deanery/LETB, find out if it is possible to amend the application for time OOP to fulfil the criteria set.

If you have any problems, contact our advisers via bma.org.uk/contactus

Further information

- The *Gold Guide* <http://specialtytraining.hee.nhs.uk/the-gold-guide/> and *Orange Book* http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4006614 sets out the rules for undertaking time OOP. Prior to making an application for time OOP, please refer to the guides in detail. The *Gold Guide* contains more specific details on the process and most deaneries/LETBs follow this process. The deanery/LETB website will have guidance specific by region.
 - The BMA website has further information available at: bma.org.uk/developing-your-career/career-progression/volunteering-abroad/how-to-apply/trainee
bma.org.uk/developing-your-career/specialty-training/out-of-programme-experience
-

Thinking of working abroad?

The BMA international department has published guidance on working abroad and working in the EEA, which is available on the BMA website bma.org.uk/developing-your-career/career-progression/working-abroad

This guidance includes information about what to think about before you go, deciding where to go and how to apply.

The BMA also has guidance on its website about working in developing countries (bma.org.uk/developing-your-career/career-progression). This guidance aims to support doctors at all stages in their careers, from trainees, specialty doctors and associate specialists, to consultants and GPs, in successfully taking time out from working as a doctor in the NHS to gaining professional experience in developing countries. It also aims to support deans and employers in the NHS to understand how best to support doctors as part of the wider workforce.

The BMA international department also works with BMA regional services to provide advice to individual members on integrating overseas work with an NHS career, including specific issues such as registration and immigration procedures and working for agencies as well as steps to take before leaving and returning to the NHS to help avoid problems.

From time to time the department also holds evening seminars around the country and aim to give a general introduction to those who are interested in temporary employment in developed or developing countries, at a postgraduate level.

For further information on the seminar dates and locations, please contact the BMA international department on 020 7383 6133.

16,000
resident doctors
turn to us each year
on employment
issues

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Visit bma.org.uk/yourcontract

Medical
academic doctors

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Medical academic doctors

Summary

This chapter provides more information about routes into academic medicine.

It also outlines what you might expect to encounter in the medical academic workplace, including information on contracts and pay.

What is academic medicine?

According to the Academy of Medical Royal Colleges: 'Academic medicine is the work undertaken by clinicians with responsibilities to both their University and their NHS Hospital Trust. They usually combine service delivery with research, teaching and/or administration.'^{*}

Trained doctors undertaking these roles are usually employed by universities, both in the medical school and beyond. Less commonly, doctors are employed by universities with postgraduate medical or healthcare centres. They usually have honorary contracts with local NHS organisations and undertake a number of fixed clinical sessions. Those doctors also with clinical commitments are known as clinical academics and are on a pay scale equivalent to that in the NHS.

Training opportunities in academic medicine

The 'Integrated Academic Training Pathway'^{*} clearly defines the key entry points into academic medicine and outlines a transparent career structure where progression is identifiable from the outset. Starting at foundation level – which gives trainees a taster of academic medicine – and progressing through two specialty phases, the Pathway is intended to be the dominant career route for medical academics. Of the training opportunities offered, the majority will be research-focused with fewer concentrating on training for educationalists.

It is important to note that, although defined as the principal career pathway into academic medicine, it is not the only route and opportunities are available to enter the academic career structure at different stages of a clinician's career, even as a consultant or GP principal.

^{*} Royal College of Physicians of London, 2004

The responsibilities of the two employers

All medically qualified academic staff working for both the NHS and a higher education institution should be employed subject to the principles recommended by Professor Sir Brian Follett in September 2001 in his Review of appraisal, disciplinary and reporting arrangements for senior NHS and university staff with academic and clinical duties. The recommendations are broadly accepted by both sectors and are known as the Follett Review Principles. The key principle is for NHS and university organisations involved in medical education and research to work together jointly to integrate the separate responsibilities.

The BMA believes that the Follett Review Principles should apply even from F1 level. ACFs in England should, therefore, hold honorary university contracts, and the BMA advises that an honorary academic contract may also be useful for residents on academic foundation programmes. These, however, are by no means automatically forthcoming.

For more details, see the BMA's *Medical academic handbook*.

AFPs (academic foundation programmes)

AFPs offer a unique training opportunity for those interested in a career in academic medicine. The programme is delivered in the F2 (foundation year 2) either as an academic rotation or integrated throughout the entire year. Under the scheme trainees receive a comprehensive introduction to academic medicine as part of their foundation programme. They will be employed by the NHS and paid under the same terms and conditions as apply to other foundation trainees. There are currently around 350 AFP places and they are offered by all foundation schools across the UK. For further information see the *Rough guide to the academic foundation programme* (UKFPO): www.foundationprogramme.nhs.uk/download.asp?file=academic_rough_guide_2013_interactive_web_version_final.pdf

You do not, however, have to undertake an academic foundation course in order to be eligible enter specialist academic training.

ACFs (academic clinical fellowships)

The ACF is the first phase of specialist academic training in England and usually leads to the attainment of a higher degree by means of a competitive peer-reviewed research fellowship or educational training programme. General clinical training and practice will still form the majority of the responsibilities of those on the fellowships, with 25 per cent of a trainee's time protected for sessions aimed at developing the necessary academic skills required to develop ideas for and prepare applications to more substantive clinical fellowships or funding to do a higher degree.

A maximum of three years (four years for a GP) is allowed to secure a research/teaching fellowship – although it is expected that one may be secured in less time – with a further three years for the completion of the higher degree. Part-time opportunities of a longer duration may also be available.

Successful applicants to an ACF will be employed by the NHS under the national terms and conditions agreed for resident doctors. They are classed as trainee members of the NIHR (National Institute for Health Research) faculty. ACFs should also have honorary academic contracts in order to have ease of access to HEI facilities and some further academic training.

To help ensure that the best candidates are attracted to ACF posts, the recruitment round for national specialty training currently takes place before the general recruitment process. However, posts do not necessarily have to be made available each year, and to allow a greater degree of flexibility for both deans and trainees the recruitment process may take place at any point within the year in which the post was allocated. Prospective applicants are therefore advised to contact the relevant dean or LETB in the first instance to check for availability and the specific application timetable. A list of deans with ACF programmes and allocated posts is available through the NIHR (National Institute for Health Research) Trainees Coordinating Centre website, along with the contact details for further enquiries.

Higher degrees

Success in obtaining a research training fellowship or a place on an educational programme which leads to a higher degree is usually seen as the end of the ACF period. At this point trainees, with the agreement of their postgraduate dean, will take time out of their clinical programme to complete the MD, PhD or equivalent higher degree.

CLs (clinical lectureships)

CL posts are the second phase of specialist academic training in England and are designed to enable trainees to complete clinical training in conjunction with post-doctoral research or higher educational training. Clinical lecturers are usually employed primarily by the higher education institution in which they hold a post. As the clinical academic timetable split will be half-half, a clinical lecturer employed by a university should also have an honorary contract with the NHS to cover their clinical duties. Trainees may have to make arrangements for this themselves. A further contract may be needed to cover out-of-hours work.

The BMA has also prepared guidance on moving from the NHS to university employment, 'Guidance note on transferring between NHS and University employment during training' bma.org.uk/academicscontracts

Clinical lecturers employed by the NHS should ask their prospective employer that they have access to the additional points on the clinical lecturer pay scale in the higher education sector.

The CL phase lasts up to four years (though this can be extended in response to time spent on maternity leave, for example) and a trainee's continued academic career development will be the responsibility of the organisation in which they are based. It would be advisable to check with the university employer on the extent to which they are likely to be flexible on the completion date before taking on the lectureship. The programme enables the trainee to undertake a substantial piece of postdoctoral research or educationalist project and also leads to the attainment of a CCT (certificate of completion of training) and the end of clinical training. Clinical lecturers are also classed as trainee members of the NIHR faculty.

Other routes

Although the three training programmes are seen as the dominant pathway for a career in academic medicine, there is flexibility, with other entry points and routes into the career framework. Other academic training posts that are not funded from the NIHR are also available. For more information, see the BMA's *Medical academic handbook*.

Medical academic training in Scotland

AFPs (academic foundation programmes) in Scotland

There are around 40 AFPs available each year in Scotland, with varying numbers of programmes available in each of the four regions. Academic programmes are advertised on the NHS Education Scotland (NES) website www.nes.scot.nhs.uk/ in June and July each year. Any vacancies that arise for individual year long programmes are also advertised separately on the NES website.

Specialist training for medical academics in Scotland

The SCREDS (Scottish Clinical Research Excellence Development Scheme) provides an integrated training and career development pathway for clinicians wishing to pursue academic and clinical training within the NHS. It allows clinicians to pursue academic and clinical training either concurrently or sequentially to provide opportunities to attain both a CCT and the experience and skills required for a senior clinical academic post.

SCREDS covers three phases of academic and clinical training.

- Clinical lectureships: usually available from ST2 and above for the duration of specialty training.
- OOP research/clinical fellows: an opportunity to focus on pursuing a higher degree, usually a PhD.
- Advanced academic career development: there are a number of opportunities for those with a higher degree, either at pre or post-CCT level.

Trainees are advised that, unlike in England, doctors employed by universities may only remain in the NHS Pension Scheme for eight years. Trainees are advised to discuss this with their employer if their academic training is likely to exceed eight years or with the BMA pensions department if they expect to remain in academia.

Further information

- NES website www.nes.scot.nhs.uk/
 - Further information on AFPs in Scotland can be found at the UK Foundation Programme Office website www.foundationprogramme.nhs.uk/pages/academic-programmes
 - Information NES and Board for Academic Medicine (2009) SCREDS: *A guide to the scheme* www.nes.scot.nhs.uk/education-and-training/by-discipline/medicine/resources/publications/scredds-guidance-to-the-scheme.aspx
 - Edinburgh Clinical Academic Track scheme (E-CAT): www.ecat.ed.ac.uk/
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Medical academic training in Wales

Wales offers training in Academic Medicine through the Academic Foundation Programme and subsequently through the WCAT W (ales Clinical Academic Training) Fellowship Programme. This offers clinical speciality training with academic research together with allocated time to complete a PhD. Academic Fellowship posts and Clinical Lecturer posts also exist within specialities.

The ACMT (Academic Core Medical Training) programme for Core Medical Trainees within Wales incorporates two years of CMT training and an additional year dedicated to pursuing an academic programme to a Master's degree. The academic component can be split throughout the programme or concentrated at the end.

During CMT, trainees plan their research programme with their academic supervisor and this is formally and separately appraised by the Academic CMT Board. Trainees have the opportunity to compete to continue an academic career in a WCAT post, a Clinical Research Fellowship or to interview for clinical training in a Higher Medical Specialities. In all cases this will be by application in open competition. Full details of the academic training scheme in Wales can be found at www.walesdeanery.org/index.php/en/wales-deanery-specialty-schools/academic-medicine.html

Medical academic training in Northern Ireland

Since 2010, Northern Ireland has been included in the centralised academic selection process. In 2011 Queen's University Belfast has, in partnership with the HSC Trusts, established sub-deaneries and conferred University Teaching Hospital Status on the major

teaching hospitals. The sub-deans will now play an integral role in the management and delivery of clinical education.

Foundation posts with an academic stream in Northern Ireland are fully integrated into the foundation programme for F2. Trainees then apply for ACL (academic clinical lecturer) posts at ST3 level or above within the academic medicine and paediatrics training programme. The NIMDTA (Northern Ireland Medical and Dental Training Agency) states that the posts 'offer candidates a comprehensive experience in clinical academic medicine alongside internationally recognised clinicians and researchers'.

Applicants will have already obtained a medical research postgraduate degree. The aim will be to finish clinical training while continuing academic development involving a programme of postdoctoral research leading to an application to a major funding body.

Recruitment to ACLs (academic clinical lectureships) occurs annually in the spring. In the first instance these posts are recruited internally from trainees at ST3 level and above.

See the *Medical academic handbook* for further details. More information is also available from the NIMDTA website: www.nimdt.gov.uk

Academic and clinical progression

The progress of all trainees who undertake postgraduate specialty training is formally assessed through the ARCP (Annual Review of Competence Progression) which reviews evidence both for a trainee's progression and the appropriateness of their clinical and academic training programmes. Full details regarding the monitoring of clinical progress and the roles and responsibilities of both trainee and supervisor are set out in the 'Reference guide for postgraduate specialty training in the UK', known as the *Gold Guide*. Academic progress is assessed by the academic supervisor across three generic domains – generic and applied research skills, research governance and communication/education. Guidance on this for assessors has been issued by the Academy of Medical Sciences and the CoPMED (Conference of Postgraduate Medical Education Deans), and is currently being revised by Health Education England and the GMC.

Supervisors

For all research projects, but particularly PhDs, the role of the supervisor is critical. Hence, the choice of supervisor is key. They will be a senior member of the academic community and you should ensure that the two of you are compatible with the right balance between supporting your creativity and having a practical eye on delivering the work on time. A checklist of what can be expected from a supervisor can be found in the BMA's *Medical academic handbook*.

Mentoring

Given the long duration of academic training and its coupling with higher specialist training, early career medical academics particularly need support in developing a career. Mentoring schemes should be as flexible as possible and should allow either party to seek an alternative partner should they feel the mentoring relationship is not working. Trainees may also wish for different mentors for different aspects of their work. The Academy of Medical Sciences (www.acmedsci.ac.uk) has established a mentoring scheme for senior academic trainees and your university or local dean may also be able to offer support in identifying a mentor.

Role of postgraduate deans

We fully expect postgraduate deans to be involved in ensuring the clinical element of training accords with national standards. The dean's office can be approached for advice and we would urge trainees to establish a good relationship with clinical and education supervisors and their training programme director (who may not be an academic) early on.

Contracts

All higher education institutions should provide information about their human resource policies to prospective employees. Terms and conditions of medical academic contracts may differ from NHS contracts. Look out for the details regarding pension schemes, annual leave and maternity leave. If you are in doubt simply view our guidance to check if your contract conforms to the agreed national model before you sign. Visit bma.org.uk/yourcontract

The extent to which terms and conditions vary from NHS contracts depends on the grade of doctor, whether the doctor undertakes clinical work and because HEIs are incorporated under individual

statutes which govern their operations, the university employing the academic. The BMA MASC (medical academic staff committee) has produced detailed information about the human resource policies at many HEIs that employ medical academics in the BMA's *Medical academic handbook*, and specific guidance on a number of institutions is available on the BMA website.

Doctors working primarily in the NHS who also undertake research and/or education at a higher education institution should hold a substantive contract of employment with an NHS employer. They should also hold an honorary academic contract that outlines the rights and responsibilities of both the employee and the employer in respect of the academic work carried out. The honorary contract will also provide trainees with ready access to the university library and other facilities.

Intellectual property

Both employers will have rules about intellectual property, which are normally agreed between the university and the employer. Whatever rules apply must be made explicit to the clinical academic trainee, in all cases.

Pay

Resident academics in training programmes and employed by higher education institutions should have pay parity with their NHS colleagues. They should be paid equivalent to a specialty trainee, with a banding supplement for any work above 40 hours per week or in out-of-hours time. Clinical academics below the level of consultant are paid on a clinical lecturer and senior clinical lecturer/reader scales, which draw on the pay scale for specialist registrars working in the NHS. These scales are agreed between MASC and the UCEA (Universities and Colleges Employers Association).

There are separate pay arrangements in Northern Ireland, Scotland and Wales, though the amounts paid have, to date, been the same. All the relevant pay scales are available on the BMA website.

Medically qualified academics who do not undertake clinical work will be subject entirely to the terms and conditions of the HEIs. This includes resident doctors who have secured grant funding for research (including from the MRC or the Wellcome Trust) but who hold a contract of employment with an academic institution. Resident

doctors taking time out of a training programme to complete a period of research or to take on teaching posts will be paid according to university pay scales or in accordance with grant funding.

See the *Medical academic handbook* for more details or contact the BMA for further advice. bma.org.uk/contactus

Moving between sectors

NHS doctors planning to move into the academic sector should note that an honorary contract with an NHS Trust/health board should be offered jointly with the contract with the substantive university employer. Retaining an honorary NHS contract while working in a university provides for some important employment protections, especially if the doctor intends to return to the NHS. The BMA recommends that all those working in the higher education sector, especially resident doctors undertaking a period of research OOP, hold honorary contracts with the NHS where possible.

A+B contracts

Some medical academics are employed on 'A+B contracts'. They are either employed:

- jointly on a full-time basis. Doctors are employed on a full-time basis either by the NHS with sessions subsumed to the university and work done in these sessions directed by the university; or employed on a full-time basis by the university and sessions subsumed to the NHS and work done in these sessions directed by the NHS; or
- on a part-time basis with both a medical and dental school and an NHS organisation (in which case the consultant will be treated as part time by both the university and the NHS employer).

Short-term or fixed-term contracts

Medical academics can sometimes be offered short-term or fixed-term contracts by higher education institutions. Doctors who are employed on short-term contracts (or more accurately, fixed-term contracts) are in a relatively more vulnerable position but they do have certain rights under the law. These are enshrined in the Fixed-Term Employees (Prevention of Less Favourable Treatment) Regulations, 2002.

Under the Regulations, fixed-term employees cannot be treated less favourably than comparable permanent employees unless the different treatment can be objectively justified. If fixed-term employees believe that their rights under these Regulations have been infringed, they should contact the BMA.

Returning to the NHS and pay progression on return to the NHS As long as they hold an honorary contract with the NHS, doctors who work in universities are entitled to incremental pay progression on return to the NHS as if they had not left. The date on which pay progression shall take place should remain unchanged. The relevant paragraphs from the resident doctors terms and conditions of service are:

- **Interpretation 135.** For the purposes of paragraph 121 to 134: 'b. service in a part- time or honorary appointment shall count in exactly the same way as service in a whole-time appointment'.

Redundancy

For medical academics employed by a university terms and conditions are determined by the type of contract they have. Universities are independent employers and will have their own policies dealing with the possibility of redundancy in relation to all staff. You will have the same statutory entitlements as any other worker but your contractual entitlement may differ from those with contracts with another employer or with the NHS. If you believe that you are threatened with redundancy you should seek BMA assistance as soon as possible.

Overseas doctors and international medical graduates

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Overseas doctors and international medical graduates

Summary

The UK immigration system is a points-based system. The points based system is not enacted through legislation so the UK Government can, and does, change the system on a regular basis.

The Points Based System consists of five tiers. Tiers 2 and 4 are most relevant to doctors or prospective medical students from outside the European Economic Area (EEA) who wish to come to the UK.

As the rules change frequently it is important to check the BMA website for the most up-to-date information at bma.org.uk/immigration

The process for doctors completing the Foundation Programme

The immigration route for overseas medical graduates completing the Foundation Programme is:

- a Tier 4 visa is needed to take up a Foundation Programme post
- at the end of the Foundation Programme, the doctor needs to 'switch' to a Tier 2 (General) visa to take up a specialty training post

Members should always check with the BMA immigration advice service before switching visas, to make sure they meet all the requirements and to ensure they make the best choices for their route through training. The Service can advise any member who is a doctor subject to the immigration rules whether they are a graduate of a UK university, already working in the UK or looking to move to the UK.

BMA immigration advice service

To help BMA members who are subject to the Immigration Rules, the international department provides an immigration advice service.

The BMA international department's immigration advisers are authorised by the Office of the Immigration Services Commissioner (OISC), to give members basic immigration advice. This includes:

- applications for leave to enter or remain in the UK which are within the immigration rules.
- diagnosis of the member's need for specific immigration advice
- provision of one-off advice

The BMA immigration advice service can be contacted on 020 7383 6133 or email internationalinfo@bma.org.uk
bma.org.uk/immigrationadvice

Further information

- Further information about immigration can be found on the BMA website bma.org.uk/immigration
 - The UK Visa and Immigration website www.gov.uk/visas-immigration
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Learning and development

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Quality professional and career development opportunities for our members:

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- Webinars
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- Revision courses
- Sci59 psychometric test
- BMA e-learning modules
- BMJ products
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Visit bma.org.uk/learning to access these and other products.

Revalidation

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Summary

Revalidation is the process for doctors to assure the General Medical Council (GMC) that they are up to date and fit to practice. The implementation of revalidation began at the end of 2012 and all doctors who wish to retain their licence to practise are now legally required to be revalidated every five years.

Revalidation

Background

Various schemes for revalidation of doctors' fitness to practise have been considered over many years and in this time a number of models for revalidation have been proposed. Revalidation was on the verge of being implemented in 2005 but was thrown off course by the Shipman Inquiry. The current system builds on the recommendations from former chief medical officer for England Professor Sir Liam Donaldson in his 2006 report 'Good Doctors, Safer Patients'. A more comprehensive overview on the background to revalidation can be found on the BMA's website bma.org.uk/practical-support-at-work/revalidation/revalidation-background

What is revalidation?

Revalidation is the process for doctors to positively affirm to the GMC (General Medical Council) that they are up to date and fit to practice. It applies to all licensed doctors in the UK working in the NHS and the private sector and all branches of practice.³ Only doctors who have GMC registration with a licence to practise are legally required to revalidate. Doctors who hold registration without a licence to practise are not required to do so. Further information on licensing for doctors can be found on the GMC website.

The process

Doctors with a licence to practise must revalidate, usually every five years. Revalidation is based on an evaluation of a doctor's practice in the workplace and doctors participate in an annual appraisal process. The appraisal is based on the GMC's *Good medical practice*. Doctors also need to collect and reflect on a range of supporting information about their practice (including evidence of continuing professional development and feedback from patients), to be discussed at their appraisal. Doctors are supported through the process of revalidation by the organisation in which they work – a 'designated body'.

3 All doctors need a licence in order to practise medicine in the UK, in addition to GMC registration.

These organisations have a statutory duty to provide the doctors connected to them with a regular appraisal and to help them with their revalidation. Designated bodies have a 'responsible officer' who, every five years, make a recommendation to the GMC that a doctor is up to date and fit to practise.

More information about the process is available on the GMC's website: www.gmc-uk.org/doctors/revalidation.asp

As a doctor in foundation or specialty training, you will revalidate in a similar way to other licensed doctors. Your 'responsible officer' will make a recommendation to us that you are up to date, fit to practise and should be revalidated. The GMC has specific guidance for doctors in training: www.gmc-uk.org/doctors/revalidation/12383.asp

For resident doctors in training posts, the processes of assessment and the ARCP/RITA cycle will provide the evidence that is required to demonstrate this. It should be noted that failure to progress to the next stage of training does not mean that the doctor is not fit to practise at the level at which they are currently working; it means they are not ready to progress yet.

BMA's seven principles on revalidation

The BMA believes that revalidation must be based on the following set of principles:

1. There must be a clear mechanism for dealing with conflicts of interest with responsible officers, including an appeals process with an independent scrutineer.
2. Remediation must be fully funded to ensure equality across branches of practice.
3. Medical royal college standards for revalidation must be equitable, fair and proportionate.
4. Knowledge tests should form no part in assessing fitness to practise, whether as part of the GMC's generic standards for relicensing or in college standards for recertification; any multisource feedback system must be validated.
5. The introduction of revalidation must be cost-effective and not put undue strain on the NHS.
6. Pilots must run independently and be fully evaluated, with the results published and fed into subsequent pilot stages.
7. There must be equality of opportunity to revalidate.

Further information

- The BMA webpages provide updates on revalidation at bma.org.uk/revalidation
 - The GMC website www.gmc-uk.org/doctors/revalidation.asp
 - GMC Online, a secure area of the GMC website designed to make administration easier for doctors www.gmc-uk.org/doctors/information_for_doctors/gmc_online.asp
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Raising
concerns and
whistleblowing

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Summary

Doctors working in the NHS face many, sometimes conflicting, challenges on a daily basis. This is part of daily working life but in some circumstances you may find you have serious concerns about what is happening around you and feel that patient care may be under threat.

Raising concerns and whistleblowing

What is whistleblowing?

The term 'whistleblowing' is the popular term applied to a situation where an employee, former employee or member of an organisation brings their concerns to people who have the power and presumed willingness to take corrective action.

All employers should have a formal policy for raising concerns, which will usually be known as the whistleblowing policy, and you should familiarise yourself with the local policy at an early stage when tackling a concern you have.

Doctors have a professional duty, under *Good medical practice*, to raise concerns. Concerns in the workplace can vary in nature but they will all have one common factor: ensuring patient safety. It is important to remember that raising a concern is different from raising a personal complaint or grievance. The Public Interest Disclosure Act 1998 gives statutory protection to employees who disclose information reasonably and responsibly in the public interest and who are victimised or dismissed as a result.

Raising concerns: the principles

- Everyone should be aware of the importance of preventing and eliminating wrongdoing at work. You should be watchful for illegal or unethical conduct and report anything of that nature that you become aware of.
- Any matter raised should be investigated thoroughly, promptly and confidentially, and the outcome of the investigation reported back to the worker who raised the issue.
- No one should be victimised for raising a concern. This means that your continued employment and opportunities for future promotion or training should not be prejudiced because you have raised a legitimate concern.
- If you are victimised after having made a disclosure under the Public Interest Disclosure Act 1998 you can bring a claim at an employment tribunal. Your employer should treat any acts of victimisation as a disciplinary offence.
- An instruction to cover up wrongdoing is itself a disciplinary offence. If told not to raise or pursue any concern, even by a person in authority such as a manager, you should not agree to

- remain silent. You should report the matter following the steps outlined in the BMA guidance documents on this issue.
- If you make a false allegation it may be a disciplinary offence.

It can be hard to know whether a situation should be raised as a concern. You should be guided by this question: if you let the situation carry on is it likely to result in harm to others? If in doubt, you should always err on the side of raising the concern with your manager/immediate superior, and you should do it as soon as you can. There is no burden on you, as the person raising the concern, to establish all the facts and provide all the necessary evidence.

The Francis Inquiry

The Francis Inquiry was a Public Inquiry chaired by Robert Francis QC into the breakdown of oversight and management over the failures at the Mid Staffordshire NHS Foundation Trust.

The report made a large number of recommendations about the scrutiny of NHS services and there has been a renewed focus on whistleblowing and raising concerns within the NHS. Robert Francis identified the vital role that resident doctors can play in raising concerns over quality of care and the importance of ensuring that resident doctors receive training in appropriate environments.

The BMA is committed to making the most of the opportunities presented by the recommendations in the Report to ensure that the NHS is providing the best possible quality of care for all of its patients. It is essential that medical staff and management jointly promote the ethos that raising concerns is not only acceptable but positive. Further information can be found on the BMA website: bma.org.uk/working-for-change/doctors-in-the-nhs/nhs-culture

Concerns about training

Concerns about training may well be bound up with patient care issues, and complaining about training may sometimes lead to raising concerns about patient care, particularly regarding clinical supervision. Issues with training may be a cause for concern for both trainees and trainers, and the GMC and postgraduate deaneries are empowered to address this type of concern.

If you want to contact the postgraduate deanery/LETB for this, your Training Programme Director would be the best first point of contact.

You can and should approach them if local routes, such as speaking to the educational supervisor, are unsuitable or unsuccessful.

The BMA has detailed guidance available ([bma.org.uk/whistleblowing](https://www.bma.org.uk/whistleblowing)) on raising concerns which covers the following areas:

- what are my contractual entitlements?
- what are my professional obligations?
- who do I approach in order to raise a concern?
- raising a concern
- will there be personal consequences for me if I raise my concerns?

Who can help you?

All NHS organisations should have a policy on raising concerns about patient safety, which sets out how concerns should be escalated within the organisation.

If you are unable to access your employer's policy, the BMA can locate this on your behalf. Approach your local BMA representative or the Local Negotiating Committee Chairman to arrange this. Your LNC Chairman and local BMA representatives can be identified by calling the BMA.

You can contact the BMA ([bma.org.uk/contactus](https://www.bma.org.uk/contactus)) and you will be given initial guidance on the issue. If there is particular support we can provide locally, you will be transferred to a relevant adviser. If in the course of raising your concern at work you feel you have been victimised, we will also put you in touch with an adviser.

Doctors for doctors, (telephone 08459 200 169) is the BMA counselling service, which can offer support for the emotional aspect of the dispute, you may be going through.

Further information

- The BMA guidance is available at [bma.org.uk/practical-support-at-work/whistleblowing](https://www.bma.org.uk/practical-support-at-work/whistleblowing)
 - BMA information on the Francis Inquiry and NHS Culture work: [bma.org.uk/working-for-change/doctors-in-the-nhs/nhs-culture](https://www.bma.org.uk/working-for-change/doctors-in-the-nhs/nhs-culture)
 - Public Concern at Work website www.pcaw.org.uk/
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The regulatory framework

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The regulatory framework

Summary

This chapter provides a summary of the regulatory framework and provides details on the BMA and the work of the resident doctors committee. It also includes information on occupational health services and sources of professional advice.

Freedom of Information Act

The Freedom of Information Act 2000, which came into force on 1 January 2005, gives the right of access to information held by public bodies. It covers England, Wales and Northern Ireland and there is a separate Freedom of Information (Scotland) Act 2002 and a separate Scottish Information Commissioner. These include the DH, NHS Trusts and independent medical practitioners. The ICO (Information Commissioner's Office) is charged with the responsibility of implementing and enforcing the Act. The Act also requires that each public body produces and maintains a publication scheme which details the types of documents produced and held by the organisation and whether they are accessible to the public. Some NHS Trusts have already established such schemes.

Under the Act, an individual is able to make a request in writing to a public body for information. The body must comply with the request within 20 working days. If it fails to comply the Information Commissioner can be asked to intervene. Non-compliance could ultimately be regarded as contempt of court leading to an unlimited fine or imprisonment.

There are, however, 24 exemptions to access that are specified in the Act. They include information relating to defence, international relations and national security. However, 16 of the exemptions are subject to the public interest test. This is a test used by public authorities to determine whether the public interest in withholding the information is greater than the public interest in disclosing it.

It should be noted that the Data Protection Act does not protect members against the release of information on clinical performance or complaints. The Data Protection Act is designed 'to protect the private lives of individuals'. Hence, if a request is received for information to be released relating to an individual's 'private life' (eg details of the person's family life or personal finances) this information is likely to deserve protection under the terms of the Data Protection Act and hence would not normally be disclosed. However, if the information relates to an individual's 'non-private' life, for example, if it concerns someone acting in an official or work capacity, this information would normally be disclosed.

GMC

The GMC is the regulatory body of the medical profession and is established as such by Act of Parliament. The GMC declares that its purpose is 'to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine'. To this end, the GMC controls entry to the medical register and determines the principles and values that underpin good medical practice. Where a doctor fails to meet the standards it has set the GMC acts 'to protect patients from harm – if necessary, by removing the doctor from the register and removing their right to practise medicine'.

The GMC exercises its powers by determining whether individuals should be registered as doctors in the UK and setting the educational standards for medical schools. The GMC's *Good medical practice* guidance sets out a doctor's professional obligations and duties, and advises on standards of good clinical care, professional relationships with colleagues, matters of probity and doctors' health.

The GMC does not deal with general complaints and can only take action when a doctor's fitness to practise is called into question. Broadly it can act in the following circumstances:

- when a doctor has been convicted of a criminal offence
- when there is an allegation of serious professional misconduct that is likely to call into question a doctor continuing in medical practice
- when a doctor's professional performance may be seriously deficient, whether or not it is covered by specific GMC guidance
- when a doctor with health problems continues to practice while unfit.

The GMC's procedures are only activated when a case is referred to the Council Members. Convictions of doctors are usually reported directly by the police. Complaints can be made by individual doctors, members of the public, or employing or other public authorities. However, the RDC advises that trainees should in most cases bring concerns about their colleagues to the attention of their supervising consultant in the first instance. The GMC has produced guidance for doctors and other healthcare professionals on referring a doctor to the GMC which is available on its website (www.gmc-uk.org/concerns/23339.asp).

It is a duty of a doctor under *Good medical practice* to report any concerns about a doctor's fitness to practise that may be putting patients at risk, to an appropriate person from the employing authority, such as the medical director. If there are either no local procedures, or they do not resolve the problem satisfactorily the concerns should be passed to the GMC. Doctors are advised to discuss any concerns with an impartial colleague or their defence body. The GMC can also give advice and, before a referral is made, any concerns can be discussed with one of its caseworkers. It can be contacted on 0161 923 6602 or on practise@gmc-uk.org

The GMC has previously taken action in circumstances where a doctor has:

- made serious or repeated mistakes in diagnosing or treating a patient's condition
- not examined patients properly or responded to reasonable requests for treatment
- misused information about patients
- treated patients without obtaining their informed consent
- behaved dishonestly in financial matters, with patients or in research
- made sexual advances towards patients
- misused alcohol or drugs.

The GMC can normally only consider complaints within five years of the incidents that are the reason for the complaint.

Fitness to practise

GMC procedures are divided into two separate stages: 'Investigation' and 'Adjudication'. In the investigation stage, the GMC investigates cases to assess the need for referral for adjudication. At the end of the investigation by the GMC of allegations against a doctor, the case will be considered by two senior GMC staff known as case examiners (one medical and one non-medical). They can:

- conclude the case with no further action
- issue a warning (which will be disclosed to a doctor's employer, where 'there has been significant departure from 'good medical practice' or there is 'cause for concern following assessment but a restriction on the doctor's registration is not necessary')
- refer the case to a FTP (fitness to practise) panel
- agree undertakings.

The adjudication stage consists of a hearing of those cases that have been referred to a fitness to practise panel. At any stage of the investigation the GMC may refer the doctor to an Interim Orders Panel (IOP). An IOP can suspend or restrict a doctor's practice while the investigation continues. FTP panels hear evidence and decide whether a doctor's fitness to practise is impaired.

From May 2008, the GMC introduced a provision for the use of the civil standard of proof (the balance of probabilities) at fitness to practise panel hearings when panelists are making decisions on disputed facts. Previously the GMC used the criminal standard of proof (beyond reasonable doubt). The requirement to move to the civil standard of proof was a result of the Shipman inquiry and the Government's subsequent white paper, *Trust, assurance and safety: the regulation of health professionals in the 21st century* published in February 2007. The balance of probabilities, as applied in the civil standard of proof, means that the tribunal need only be satisfied that the alleged facts are more likely than not to have happened. The criminal standard of proof of 'beyond reasonable doubt' meant that the tribunal had to be sure that the case was proven.

Panel hearings are the final stage of the GMC's procedures following a complaint against a doctor. Panels of three to five medical and non-medical members are appointed by the GMC. In addition to the chairman, who is not necessarily medically qualified, there must be at least one medical and one non-medical member on each panel. A legal assessor sits with each panel and advises on points of law and fact.

Once the panel has heard the evidence, it must consider three matters: whether the facts alleged have been found proved; whether, on the basis of the facts found proved, the doctor's fitness to practise is impaired; and if so, whether any action should be taken against the doctor's registration. The application of the standard of proof applies only to the first of these questions.

In deciding on the appropriate sanction, which could be from taking no action to erasing the doctor from the Medical Register, the panel must have regard to the Indicative Sanctions Guidance. Doctors have a right to appeal to the High Court against any decision by a panel to restrict or remove their registration. The CHRE (Council for Healthcare Regulatory Excellence) may also appeal against certain decisions if they consider the decision was too lenient.

Duties of a doctor

The GMC sets out the duties of a doctor registered with the Council. Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- make the care of your patient your first concern
- protect and promote the health of patients and the public
- provide a good standard of practice and care
 - keep your professional knowledge and skills up to date
 - recognise and work within the limits of your competence
 - work with colleagues in the ways that best serve patients’ interests
- treat patients as individuals and respect their dignity
 - treat patients politely and considerately
 - respect patients’ right to confidentiality
- work in partnership with patients
 - listen to patients and respond to their concerns and preferences
 - give patients the information they want or need in a way they can understand
 - respect patients’ right to reach decisions with you about their treatment and care
 - support patients in caring for themselves to improve and maintain their health
- be honest and open and act with integrity
 - act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
 - never discriminate unfairly against patients or colleagues
 - never abuse your patients’ trust in you or the public’s trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Good medical practice

The Council published the most recent edition of *Good medical practice* in 2013. The guidance sets out the principles and values on which good practice is founded and standards of competence, care and conduct expected of doctors in all aspects of their professional work. *Good medical practice* sets broad standards on clinical care; teaching, training and appraisal; relationships with patients; dealing with problems in professional practice; working with colleagues; probity and health.

Further information

- *Good medical practice*, GMC (2013) www.gmc-uk.org/guidance/good_medical_practice.asp
 - GMC website: www.gmc-uk.org
 - CHRE website: www.chre.org.uk
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Occupational health services

All NHS employers must ensure that their staff have access to confidential occupational health services, including a consultant in occupational health medicine. Where the occupational health team is made up of an occupational health nurse and/or non-consultant occupational health physicians, managers are obliged to ensure that there is access to and advice from a consultant. The DH has provided a national policy lead on occupational health issues for some years through *The management of health, safety and welfare issues for NHS staff* (1998) and *The effective management of health and safety services in the NHS* (2001). In 2004, the DH circulated a draft of the first NHS Occupational Health and Safety Strategy for England, which set out its vision for a safer, healthier NHS.

The strategy was developed in response to The National Audit Office report *A safer place to work* (2003). The responsibility for encouraging the implementation of good occupational health and safety policy across the NHS has now been transferred to the NHS Employers organisation, which will act in an advocacy and advisory role to NHS senior managers. See www.nhsemployers.org

Through their occupational health services, NHS employers should protect the health of their staff from physical and environmental health hazards arising from their work or conditions of work; reduce risks at work which lead to ill-health, staff absence and accidents, and help management to protect patients, visitors and others from staff who may represent a hazard, such as from infectious disease.

The functions of an occupational health service are to advise employees and employers about the interaction between health and work, to maximise the beneficial effects of this interaction and to minimise the adverse effects. It should be noted that occupational health is primarily a preventative and not a treatment service, but much of the output of an effective occupational health service is directly or indirectly therapeutic to organisations and the individuals employed by them.

Further information

- BMA advice on Occupational Health [bma.org.uk/occupational health](http://bma.org.uk/occupational_health)
 - NHS Employers www.nhsemployers.org/
 - *Safe and well at work: Occupational health and safety framework for NHS Scotland* www.scotland.gov.uk/Publications/2011/03/17125508/0
 - *A safer place to work* (2003) www.nao.org.uk/publications/0203/nhs_health_and_safety.aspx
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Violence against doctors

The British Crime Survey has reported that doctors and nurses are among those most at risk of threats and assaults in the workplace. A BMA report, *Violence at work, the experience of UK doctors* reported that a third of hospital doctors had experienced some form of violence in the workplace in the previous year and that doctors working in A&E, psychiatry and obstetrics and gynaecology were even more likely to have experienced violence. The paper also noted that the under-reporting of incidents was a widespread problem.

The paper recommended training for doctors on the management of potentially violent situations, partnerships with other relevant local agencies (such as the police) and raising awareness of patients' responsibilities and acceptable behaviour. Doctors are advised and encouraged to report violent incidents and, through their LNC, to ensure that employers put in place protocols for recording such incidents and effective strategies for dealing with the problem. The HSE has also produced guidance on the assessment and management of violence against staff in the healthcare sector.

The misuse of alcohol and other drugs

The misuse of alcohol and other drugs is a major threat to health, family, livelihood and potentially, in the case of doctors, a threat to patients. The problems are widespread, a 1998 BMA report suggesting that some one in 15 doctors in the UK may suffer from some form of dependence, and noting that two-thirds of all cases referred to the GMC health procedures involve the misuse of alcohol and other drugs. Although it is widely perceived that those affected are predominantly male and approaching retirement, specialist units with experience of treating doctors note that both female and male doctors of all ages are affected. Doctors who misuse alcohol

are often at the same time involved in misuse of other drugs, and doctors whose primary problem appears to be alcohol may also be misusing hypnotics, anxiolytics, opioids or amphetamines.

Guidance from the GMC in *Duties of a doctor* is explicit in the responsibility that doctors have to prevent any risk to patients arising from their own ill-health or that of their colleagues. There are additional responsibilities under health and safety regulations, which impose duties on all individuals regarding their own health and safety and that of their colleagues.

Once in treatment, medical practitioners do remarkably well, and early recognition and treatment considerably increase the chance of successful rehabilitation. To facilitate this, the BMA recommends that every employing authority must have a well-publicised drug and alcohol policy. Such a policy must include an acknowledgement that organisations within the health service exist to provide high standards of healthcare and such high standards should also be available to employees of these organisations. Policies should provide for involvement of occupational health services, appropriate sick leave, access to treatment services and retention of employment when the employee cooperates. Policies should be supportive rather than punitive. Advice on responsibilities for their own health and that of colleagues should be included in any induction programme. Given below under 'Sources of professional advice' is a list of organisations, which are able to provide further advice and counselling.

Transmission of infection

In March 2007 the DH published *Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New healthcare workers*. This aims to clarify the position on testing for blood-borne viruses for NHS staff.

The guidance recommends that, on appointment, all new healthcare workers should have standard healthcare clearance checks. All new workers should have checks for tuberculosis disease/immunity and be offered hepatitis B immunisation, with post-immunisation testing of response and the offer of tests for hepatitis C and HIV. It states that where a new member of staff's duties include performing exposure-prone procedures (EPPs), additional healthcare clearance should also be obtained before confirmation of an appointment. This includes being non-infection for:

- HIV (antibody negative)
- hepatitis B (surface antigen negative, or if positive e-antigen negative with a viral load of 10 genome equivalents/ml or less); and
- hepatitis C (antibody negative or, if positive, negative for hepatitis C RNA).

The DH guidance does not recommend mandatory large-scale screening of healthcare workers for blood-borne viruses. It instead recommends that only the following groups of staff should be tested:

- healthcare workers who are new to the NHS
- healthcare workers moving to a post that involves EPPs (where workers have not undertaken EPPs before); and
- returning healthcare workers.

Further information

- *Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New healthcare workers (2007)* http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073132
 - BMA guidance: bma.org.uk/occupationalhealth
 - *Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV for new healthcare workers with direct contact with patients (Scotland)* www.scotland.gov.uk/publications/2008/04/25104624/0
 - *Practice of Exposure-prone medical procedures by healthcare workers living with HIV or Hepatitis B* SGHD/CMO(2014) 2 (Scotland) [www.sehd.scot.nhs.uk/cmo/CMO\(2014\)02.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2014)02.pdf)
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Further information is available from HPA, now Public Health England www.hpa.org.uk/topics/infectiousdiseases/infectionsaz/bloodbornevirusesandoccupationalexposure/ukap/

Sources of professional advice

BMA Counselling is a service available 24/7 and allows doctors to speak to a team of fully-qualified counsellors. Any issue causing distress or difficulty can be discussed including:

- workplace problems
- exam pressures
- stress and anxiety
- loss of confidence
- personal and relationship difficulties
- alcohol and drug misuse
- bereavement
- debt and other financial concerns.

The telephone number for the BMA counselling service is 08459 200 169. All calls are charged at local rates.

The Doctors for Doctors Unit is run by the BMA and offers doctors in distress or difficulty the option of speaking in confidence to another doctor. Our team of doctor- advisers work with you to gain insight into your problems, supporting and helping you to move on by adopting a holistic approach to your situation. A wide range of concerns are dealt with including doctors who have been referred to the GMC, bullying at work, mental health issues and alcohol problems. The Doctors for Doctors service is completely confidential and is not linked to any other internal or external agencies. Simply call 08459 200169 and ask for a doctor-adviser. Please visit bma.org.uk/doctorsfordoctors for further information or email info.d4d@bma.org.uk

Other sources of advice

The Sick Doctors Trust provides a proactive service for doctors with addiction problems, and provides a 24-hour advice and intervention service. It facilitates admission to appropriate treatment centres and introduction to support groups. The telephone number is 0370 444 5163 and the website is www.sick-doctors-trust.co.uk

The British Doctors and Dentists Group is a support group of recovering medical and dental drug and alcohol misusers. The telephone number is 020 7487 4445 and the website is www.bddg.org/

The Sick Doctor Scheme of the Association of Anaesthetists is available to all anaesthetists and can be contacted on 020 7631 1650. The website is www.aagbi.org/professionals/welfare/welfare-schemes

British International Doctors Association has a health counselling panel, which can advise in particular those with problems where cultural or linguistic factors are prominent. For further information see www.bidaonline.co.uk/ Contact details are 0161 456 7828, email is bida@btconnect.com.

The Doctors' Support Network is a self-help group for doctors who are currently suffering from or have suffered from a serious mental health problem. The telephone number is 0844 395 3010 and the website is www.dsn.org.uk

The BMA (British Medical Association)

The BMA is a voluntary association set up in 1832 'to promote the medical and allied sciences and for the maintenance of the honour and interests of the medical profession'. It is the professional association of doctors in the UK and is registered and certified as an independent trade union under employment legislation. The BMA has sole bargaining rights for all NHS doctors employed under national agreements, irrespective of whether or not they are members. It is also recognised by many employers of doctors practising in other fields. The BMA offers advice to members on contractual and professional matters and provides individual and collective representation at a local level through BMA regional services. As a spokesperson for the medical profession to the public, the Government, employers, MPs and the media, the BMA addresses matters as wide ranging as medical ethics and the state of the NHS.

BMA RDC (resident doctors committee)

The RDC's purpose and remit is to consider and act in matters affecting those engaged in hospital practice in the training grades, including matters arising under the National Health Service Act or any Act amending or consolidating the same and to watch the interests of hospital medical staff in the training grades in relation to those Acts. bma.org.uk/RDC

National and regional resident doctors committees

Resident doctors in the three devolved nations of Scotland, Wales, and Northern Ireland are represented by their national RDCs. Resident doctors in the English regions are represented by RRDCs (regional resident doctors committees). These committees send members to the UK RDC which is responsible for representing all resident doctors in the UK.

JNC(R) (Joint Negotiating Committee (Residents))

It is through the JNC(R) that the RDC Terms and Conditions of Service and Negotiation Subcommittee negotiate with the Department of Health, NHS Employers and the devolved administrations on matters concerning terms and conditions of service of hospital resident staff.

BMA divisions

The BMA divisions are the local branches of the Association, based on geographical areas, and cover all branches of practice. Every UK member of the BMA is automatically a member of one of 204 divisions. Each division should have a chairman, secretary and an executive committee including representatives of the branches of practice locally. bma.org.uk/divisions

LNCs (local negotiating committees)

LNCs are now established in almost all NHS organisations which employ doctors. LNCs consist of local representatives of all grades of doctor including resident doctors employed by the organisation who will meet regularly to identify issues for negotiation with local management and agree their objectives. They will meet with management representatives in a joint negotiating committee in order to conclude and monitor the application of local agreements and agree and monitor arrangements for the implementation of national agreements within the organisation. Professional and administrative support to LNCs is provided by BMA regional services. bma.org.uk/lnc

BMA council

The council is the principal executive committee of the trade union and sets the strategic direction of the BMA in line with policy decided by the representative body at the annual representative meeting. Council is responsible for the formulation of policy throughout the year and for ensuring the implementation of that policy.

Council members are elected from a single UK constituency. Half of BMA council is elected biennially by postal ballot of the membership of the BMA. Council delegates its authority to seven major branch of practice committees including the RDC. There are also committees for armed forces doctors (which has representatives of the medical reserves) and for private practice. bma.org.uk/ukcouncil

BMA board of directors

The directors are responsible for the management of the finances and general administration of the BMA. They ensure the implementation of the strategic and operational objectives and resolutions made by council, pursuant to the Articles of the Association.

ARM (annual representative meeting)

The ARM determines the policy of the BMA. The representatives are either elected by the BMA divisions or are appointed by branch of practice committees.

The Joint Medical Consultative Council

The Joint Medical Consultative Council was established in 1948 as the JCC (Joint Consultants Committee). It was set up by the medical royal colleges and the BMA, as a committee able to speak for the consultant body with one voice. In a review of its constitution in 2007, the Council agreed to modify its terms of reference and explicitly acknowledge changes to its constitution over a number of years, so that it was no longer a consultant committee. While consultants continue to predominate among its members, there is now strong representation from the RDC on the committee.

The JMCC represents the medical profession in discussions with the DH on matters relating to the maintenance of standards of professional knowledge and skill in the hospital service, the encouragement of education and research, and to discuss with it the key medico-political issues of the day. The members of the Council include the presidents of the royal colleges and their faculties and representatives of the main BMA branch of practice committees representing consultants, GPs, staff and associate specialist doctors, and trainees. Half of each quarterly meeting is devoted to discussions with the Department of Health led by the chief medical officer for England. The Council also has a number of working groups on which its constituent bodies (and other organisations) are represented and through which it undertakes further work and seeks advice. The areas of work covered include independent healthcare, the GMC, NHS IT and liaison with the NHS Confederation. Further information is available here www.jointconsultantscommittee.org.uk/index.php?p=What+is+the+JMCC%3F

BMA advice and support

Each of the BMA branch of practice committees and conferences, as well as the ARM, are supported by a professional secretariat based in BMA House in London. There are also national offices for Scotland, Wales and Northern Ireland based in Edinburgh, Cardiff and Belfast where the committee secretariats for the national branch of practice committees are based. The BMA also has a number of regional centres staffed by secretaries, employment advisers and industrial relations officers who provide support to regional and local committees, help and advice in disputes or negotiations with hospital management. bma.org.uk/contactus

The BMA can also provide specialist advice through its board of medical education, medical ethics committee and board of science. All these committees and the branches of practice are also assisted by the BMA's public affairs division, including its parliamentary unit. The BMA press office aims to maintain a high profile for the Association, the BMJ Publishing Group and the wider medical profession. It promotes positive news and features coverage of BMA activities and events and of the work of individual doctors and medical teams. The press office offers media training to members who have agreed to act as spokesmen and women, whether as members of national committees such as the RDC or as locally elected honorary public affairs secretaries. Individual members of the BMA who are facing media enquiries can seek help from the press office at any time by calling 020 7383 6254.

Further information

- *MyBMA: A guide to membership benefits* bma.org.uk/membership/my-membership
 - Articles of the Association and Byelaws of the BMA
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‘Most resident doctors have little knowledge of their rights or the law and even if they do, they don’t want to cause a fuss. But having a contract is absolutely vital to ensure you are protected.’

Specialty registrar, London

Simply view our guidance to check if your contract conforms to the agreed national model before you sign.

We can help you be as prepared as you possibly can at this vital stage in your career.

Visit bma.org.uk/yourcontract

Appendices

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Appendix 1**Model Contract**

For the Scottish model contract, please see PCS(DD)2007/7
[www.sehd.scot.nhs.uk/pcs/PCS2007\(DD\)07.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2007(DD)07.pdf)

STATEMENT OF PARTICULARS OF EMPLOYMENT FORMING PART OF THE CONTRACT FOR HOSPITAL MEDICAL AND DENTAL STAFF IN THE GRADES OF SPECIALTY REGISTRAR, SPECIALIST REGISTRAR, SENIOR HOUSE OFFICER, FOUNDATION HOUSE OFFICER, HOUSE OFFICER AND PRE-REGISTRATION HOUSE OFFICER AND DOCTORS IN PUBLIC HEALTH MEDICINE AND THE COMMUNITY HEALTH SERVICE

For Specialist and Specialty Registrars it will be necessary to incorporate into the model contract below, paragraphs as appropriate from the previous model contract required specifically for SpRs as per AL(MD)2/96 or its successor.¹

[Insert: Name and address of employing authority/Trust]

Date

Dear

Offer of appointment

1. (a) I am instructed by the [insert name of employing authority/Trust] to [offer you]* [confirm the offer of]* an appointment as [insert job title and grade] at [insert name of hospital(s)] commencing on [for a period of terminating on]*
- (b) The date of the start of your period of continuous employment is For these purposes, your employment with [insert name of previous employer] [is]* [is not]* included in the period of continuous employment.

Applicable collective agreement

2. Your appointment will be subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service (England and Wales) as amended from time to time [and any reference in those Terms and Conditions to an employing Authority shall be construed as if it were to include a reference to an employing Trust].*²

Duties

3. (a) Your hours and duties are as defined in the attached job description (For rotations, the job description may differ for each individual post/placement). You will be available for duty hours which in total will not exceed the duty hours set out for your working pattern in paragraph 20 of the Terms and Conditions of Service.
- (b) Your working pattern is described as [full shift]* [partial shift]* [24 hour partial shift]* [on-call rota]* [hybrid comprising [full shift]* [partial shift]* 24 hour partial shift]* [on-call rota]*** with controls on hours as defined in the Terms and Conditions of Service paragraph 20.
[For staff contracted as full-time staff
You will receive a base salary as detailed in Table 1, Appendix 1 of the Terms and Conditions of Service.]*
[For staff contracted as part-time staff
- (c) You will receive a basic salary determined by your actual hours of work as a proportion of the full-time basic salary as detailed in Table 1, Appendix 1 of the Terms and Conditions of Service, using the principles set out in '*Equitable Pay for Flexible Medical Training*' (NHS Employers, 2005).³
- (d) A non pensionable supplement at payband [*insert payband*] will be payable in accordance with paragraph 22 of the Terms and Conditions of Service (for rotations, banding supplements may differ for each individual post/placement).⁴
- (e) Banding supplements may be altered (in accordance with paragraphs 6(e) and 7(c) below) in the light of changes in working patterns in order to make posts compliant with the New Deal and the Working Time Regulations as amended. If the payband changes, you will be issued with a letter of variation (in accordance with paragraph 7 below). Pay protection will apply in accordance with paragraph 21 of the Terms and Conditions of Service.⁵

Pay

4. (a) Your base salary will be £ [*insert figure*] per annum, paid monthly [and will progress by annual increments to £ [*insert figure*] per annum]* in accordance with the current national agreed salary scale for your grade. (These rates are subject to amendment from time to time by national agreement.) See Note 1.
[(b) Your incremental date will be [*insert date*]]*

- [(c) You will receive, in addition to your base salary a supplement at the rate of% of your base salary for duty contracted at [Band 1 A/B/C]* [Band 2 A/B]* [Band 3]* [Band FA/FB/FC]* as set out in Paragraph 3(d) above, which will be payable monthly. (These rates may be amended from time to time by national agreement).]*⁶
- [(d) In addition, you will be paid the following allowances: *eg peripheral allowances, London Weighting*]*

Pension

5. (a) You will be entitled to [become] [continue to be] * [delete as appropriate] a member of a NHS Pension Scheme subject to its terms and rules, which may be amended from time to time. Details of the NHS scheme are given in the scheme guide, which is enclosed.
- (b) You are contracted out of the State Second Pension Scheme.¹⁴
- (c) Pay supplements over and above base salary are non-pensionable.
For staff contracted to work 40 or more hours of duty per week
- (d) Your pensionable pay for contributions purposes must be based on your actual whole-time basic pay (1.0) only. *For staff contracted to work less than 40 hours of duty per week:*⁷ Your pensionable pay for contributions purposes will be the appropriate proportion of actual whole-time basic pay (1.0). However, your contributions must also be paid on any additional hours of duty you work between your contracted hours and a maximum of 40 hours per week.
- (e) Your employer must make arrangements to track and record these additional hours (see Paragraph 5(e) above) for pension purposes.

Monitoring of working patterns

6. (a) The Trust is contractually obliged to monitor resident doctors' New Deal compliance and the application of the banding system, through robust local monitoring arrangements supported by national guidance. You are contractually obliged to co-operate with those monitoring arrangements.
- (b) These arrangements will be subject to:
- review by the regional improving resident doctors working lives action team (or equivalent); and
 - for the Trust, the performance management systems.

- (c) The Trust must collect and analyse data sufficient to assess hours' compliance and/or to resolve pay or contractual disputes. Therefore, when the Trust reasonably requests you to do so, you must record data on hours worked and forward that data to the Trust.
- (d) The Trust is required to ensure that staff in all training grades comply with the controls on hours of actual work and rest detailed in sub-paragraph 22.a of the Terms and Conditions of Service, and with the requirements of the Working Time Regulations as amended from time to time.⁸
- (e) You are required to work with your employer to identify appropriate working arrangements or other organisational changes in working practice which move non-compliant posts to compliant posts and to comply with reasonable changes following such discussion.

Revision to pay banding

- 7. (a) The Trust will notify you in writing of its decision on banding.
- (b) Full details of the procedure for appealing against banding decisions are in the Terms and Conditions of Service sub-paragraph 22.l.
- (c) Full details of the procedure for rebanding posts are in the Terms and Conditions of Service sub-paragraph 22.m.

Notice

- 8. You are entitled to receive notice of termination of employment and are required to give [insert name of employing authority/Trust] notice. See also Note 2.4

Registration and insurance

- 9. You are required to be registered with the [General Medical Council]* [and]* [General Dental Council]* throughout the duration of your employment. See also Note 3.9

Additional work

- 10. You agree not to undertake locum medical or dental work for this or any other employer where such work would cause your contracted hours (or actual hours of work) to breach the controls set out in paragraph 20 of the Terms and Conditions of Service.

Residence

- 11. [The appointment requires you to be resident at [insert name of hospital]. No charge will be made for lodgings, in accordance with the Terms and Conditions of Service. See also Note 4]*
[The appointment requires you to be resident in [insert name

of hospital house or flat]. The terms of your occupation are set out in the enclosed tenancy agreement/licence.

See also Note 4]*

[The appointment does not require you to reside in hospital, but you have chosen to do so; and a deduction from salary for lodgings will accordingly be made, in accordance with the Terms and Conditions of Service.

See also Note 4]*

[The appointment does not require you to reside in hospital, but you have chosen to do so; and the terms of your occupation of [insert address of hospital house or flat] are set out in the enclosed tenancy agreement/ licence. See also Note 4]*

[It is your responsibility to ensure that when on-call you will be available by telephone and able to reach your hospital in time to meet your clinical commitments]*

Leave

12. (a) You will be entitled to weeks' annual leave with full pay each year. The Trust's leave year runs from
- (b) In the current leave period [insert dates] your entitlement will be weeks. (c) Full details of both annual leave and sick leave allowances and the conditions governing those allowances and study leave, are set out in the Terms and Conditions of Service.

Property

13. (a) [Insert name of employing authority/Trust] accepts no responsibility for damage to or loss of personal property, with the exception of small valuables handed to their officials for safe custody. You are therefore recommended to take out an insurance policy to cover your personal property.
- (b) Notwithstanding (a) above, [Insert name of employing authority/Trust] undertakes, so far as is reasonably possible, to ensure that lodgings are maintained in a secure condition.
- (c) You should, through the exercise of normal diligence, also seek to maintain the security of your lodgings.

Deductions

14. The [insert name of employing authority/Trust] will not make deductions from or variations to your salary other than those required by law without your express written consent.

Sickness Absence

15. The provisions relating to absence by you because of sickness appear in paragraph 225-244 of the Terms and

Conditions of Service.

Grievance Procedures

- 16. The grievance procedures, which apply to your employment, are set out in [...]. [*Note: employing organisation to add reference to local procedures*]¹⁵

Disciplinary Matters

- 17. Wherever possible, any issues relating to conduct, competence and behaviour should be identified and resolved without recourse to formal procedures. However, should we consider that your conduct or behaviour may be in breach of our code of conduct, or that your professional competence has been called into question, the matter will be resolved through our disciplinary or capability procedures and will be subject to the appeal arrangements set out in those procedures (which will be consistent with the 'Maintaining High Professional Standards in the Modern NHS' framework).¹⁶

Acceptance

- 18. If you agree to accept the appointment on the terms specified above, please sign the form of acceptance on the following page and return it to me. A second signed copy of this is attached, which you should also sign, and retain for your future reference.

Yours faithfully

Signature On behalf of

NOTES

[]*: A square bracket followed by an asterisk indicates 'delete as necessary'.

1. Your salary gives years' incremental credit for previous service. If you have any enquiry about how this has been calculated, please contact [insert name and address of Personnel Officer].

2. (a) The Departments and the profession have agreed that minimum periods of notice should be applied as follows, unless there is agreement by both parties to a contract that a different period should apply:

House Officer	2 weeks
Foundation House Officer 1	2 weeks
Foundation House Officer 2	1 month
Senior House Officer	1 month
Specialty Registrar (Fixed Term)	1 month
Specialty Registrar (Core Training)	1 month ¹⁷
Specialty or Specialist Registrar	3 months ^{10, 13}

- (b) The Employment Rights Act 1996 provides entitlement to minimum periods of notice, dependent upon an employee's length of continuous employment, as follows:

Period of continuous employment	Notice entitlement
1 month or more but less than 2 years	Not less than 1 week
2 years or more but less than 12 years	Not less than 1 week for each year of continuous employment
12 years or more	Not less than 12 weeks

3. Copies of HC(89)34 and the leaflet on indemnity arrangements issued in December 1989 (are enclosed)* [may be obtained on request]* You are normally covered by the NHS Hospital and Community Health Services indemnity against claims of medical negligence. However, in certain circumstances (especially in services for which you receive a separate fee) you may not be covered by the indemnity. The Health Departments therefore advise that you maintain membership of your medical defence organisation.¹¹

- 4. Copies of the enclosure to HSC2000/036 relating to standards of residential accommodation [are enclosed]* [may be obtained on request]*.¹²
- 5. Copies of HSC 2000/031 – Modernising Pay and Contracts for Hospital Doctors and Dentists in Training, [are enclosed]* [may be obtained on request]*.

PLEASE DO NOT DETACH

I hereby [accept]* [confirm my acceptance of]* the offer of appointment mentioned in the foregoing letter on the terms and subject to the conditions referred to in it.

Signature Date

This offer, and acceptance of it, shall together constitute a contract between the parties.

Appendix 2

Approval to change band form

APPROVAL TO CHANGE BAND			
Trust:		Hospital:	
Specialty(ies):			
Numbers of Doctors in Working Arrangement by Grade			
PRHO:	SHO:	SpR:	Other:
Working Pattern:			
Current Banding:	Proposed Banding:	Effective Date:	

Stage	Evidence Required	Documentation	Confirmed Y/N
1a. Consult post-holders on proposed changes and obtain agreement of the majority participating in the working arrangements.	Approval of majority of current/incoming post-holders	Template signed by Trust junior doctor representative confirming agreement of majority of current/incoming post-holders	
1b. Submit details of the new working arrangements to the Action Team for information and invited comment.	Full details of proposed working arrangements and/or rota summary (eg from ND2000 software)	Letter signed by Action Team Chair or delegated authority confirming theoretical compliance of working arrangements	
1c. Obtain agreement from Clinical Tutor for education purposes.	Full details of proposed working arrangements Comments of Action Team	Letter signed by Dean or delegated authority confirming educational acceptability of working arrangements	

If exceptionally and because of the impracticality of full implementation of new working arrangements a Trust wishes to offer future posts at an expected banding in advance of actual monitoring, approval must be sought from the Regional Action Team (or its equivalent) in advance of making any such offer. Any offer made in these circumstances will be strictly provisional, and must be confirmed by monitoring following the implementation of new working arrangements.

Stage	Evidence Required	Verification	Confirmed Y/N
2. Submit request for provisional approval of working arrangements to Action Team	Signed letter from Trust giving reasons for inability to fully monitor before rebanding. Evidence of full or partial testing/monitoring of proposed arrangements	Letter signed by Action Team Chair or delegated authority authorising an offer of provisional banding.	
Current Banding:	Provisional New Banding:	Implementation Date:	
Action Team Signatory		Date:	

Stage	Evidence Required	Verification	Confirmed Y/N
3. Monitoring of working pattern and confirmation of banding	Completed monitoring returns from 75% of doctors on rota over full 2 week period Summary of monitoring results	This signed template	
Previous banding:	Verified New Banding:	Effective Date:	

Trust Signatory _____ Date: _____
(Designation)

Rota Signatory _____ Date: _____
(Junior Doctor LNC representative)

Action Team Signatory _____ Date: _____
(Designation)

Appendix 3

Derivation of the Riddell formula

Starting from this equation:

$$\text{Average hours per week} = \frac{\text{total hours worked when not on leave}}{\text{weeks worked in rota cycle when not on leave}} \quad (1)$$

we must identify the variables that can be extracted from a rota to allow us to identify the numerator, total hours worked when not on leave, and the denominator, weeks worked in the rota cycle. We will use the example five-week rolling rota again to illustrate how the Riddell formula is derived.

	Mon	Tues	Weds	Thurs	Fri	Sat	Sun	Hours
1	On-call	Day	Day	Day	On-call	-	-	72
2	Day	Day	On-call	Day	Day	-	-	56
3	Day	On-call	Day	Day	Day	On-call	On-call	104
4	Day	Day	Day	On-call	Day	-	-	56
5	Day/AL	Day/AL	Day/AL	Day/AL	Day/AL	-	-	40

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Day = 9am to 5pm = 8hrs

On-call = 9am to 9am = 24hrs

Total hours worked when not on leave

To determine total hours worked when not on leave (that is the numerator for our equation) we can take the total hours worked in the entire rota cycle (328 in our example) and subtract the week of annual leave (40 in our example). This is fine for rotas for which leave occurs in convenient multiples. In the case of our example, one week leave in every five equates to leave requirement of:

$$\frac{52}{5} = 10.4 \text{ weeks per year}$$

5

For rotas in which leave does not occur in such convenient multiples, we must first determine the proportion of leave which a resident is entitled to in each rota cycle. This is expressed as:

$$\frac{\text{Leave}}{\text{number of weeks in rota cycle}} \quad (2)$$

52

By multiplying this equation (2) by the number of hours in the leave week we now have a figure (in hours) for the amount of annual leave the resident is entitled to in each rota cycle of a specific rota. If we subtract this figure from the total hours worked in the entire rota cycle, we determine the 'total hours worked when not on leave', which is our numerator.

Thus, total hours worked when not on leave

$$= \text{Total hours in rota} - [\text{hours in leave week} \times (\text{leave entitlement} \times \text{weeks in rota cycle})] \quad (3)$$

52

Weeks worked in rota cycle when not on leave

This is the denominator for our equation. In our example, to determine the number of weeks worked in the rota cycle when not on leave we need to take the five rostered weeks and subtract the one week of leave, giving four weeks.

To apply this to all rota types, we must take the number of weeks in the rota cycle and subtract the proportion of leave to which each resident is entitled. This last figure we determined in equation (2).

Thus:

Weeks worked in rota cycle when not on leave

$$= \text{Weeks in rota cycle} - \frac{(\text{leave entitlement} \times \text{weeks in rota cycle})}{52} \quad (4)$$

The Riddell formula

Therefore, taking equation (1)

$$\text{Average hours per week} = \frac{\text{total hours worked when not on leave}}{\text{weeks worked in rota cycle when not on leave}} \quad (1)$$

we can substitute in equations (3) and (4) to give:

$$= \frac{\text{total hours in rota cycle} - \text{total hours in rota} - [\text{hours in leave week} \times (\text{leave entitlement}/52 \times \text{weeks in rota cycle})]}{\text{weeks in rota cycle} - (\text{leave entitlement}/52 \times \text{weeks in rota cycle})}$$

If:

A = total leave entitlement for the year (in weeks)

B = number of weeks in the rota cycle

C = number of hours in a leave week

D = total hours worked in the rota cycle if no leave is taken

E = $(A/52 \times B)$ Then:

$$\text{Average hours per week} = \frac{D - (E \times C)}{B - E}$$

Acronyms

AAC	Advisory Appointments Committee
ACCEA	Advisory Committee on Clinical Excellence Awards
AL	Advance Letter
AVC	Additional Voluntary Contribution
BMA	British Medical Association
CHRE	Council for Healthcare Regulatory Excellence
CC	Consultants committee
CCST	Certificate of Completion of Specialist Training
CCT	Certificate of Completion of Training
CEA	Clinical Excellence Award
CCG	Clinical commissioning groups
CoPMED	Conference of Postgraduate Medical Education Deans
CPD	Continuing Professional Development
DCC	Direct Clinical Care
DDRB	Doctors and Dentists Review Body
DH	Department of Health
EC	European Commission
EL	Executive Letter
EPP	Exposure Prone Procedure
EWTD	European Working Time Directive
GDC	General Dental Council
GMC	General Medical Council
GP	General Practitioner
GWC	General Whitley Council
HA	Health Authority
HC	Health Circular
HMRC	HM Revenue & Customs
HSC	Health Service Circular
HSE	Health and Safety Executive
HSG	Health Service Guideline
ICO	Information Commissioner's Officer
JMCC	Joint Medical Consultative Council
JNC(R)	Joint Negotiating Committee (Residents)
LETB	Local Education Training Board
LNC	Local Negotiating Committee
MAC	Medical Advisory Committee
MASC	Medical academic staff committee
MHO	Mental Health Officer

MRC	Medical Research Council
NCAS	National Clinical Assessment Service
NCSSD	National Counselling Service for Sick Doctors
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NHSPS	National Health Service Pension Scheme
NICE	National Institute for Health and Clinical Excellence
NPSA	National Patient Safety Agency
NWDB	National Workforce Development Board
PA	Programmed Activity
PASs	Planned Additional Sessions
PFI	Private Finance Initiative
SPA	Supporting Professional Activity
SpR	Specialist Registrar
TCS	Terms and Conditions of Service
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981

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